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# Federal Register

Tuesday
September 3, 1985

## Selected Subjects



CONTINUED INSIDE

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# Selected Subjects

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**Reader Aids**
Additional information, including a list of public laws, telephone numbers, and finding aids, appears in the Reader Aids section at the end of this issue.

## CFR PARTS AFFECTED IN THIS ISSUE

A cumulative list of the parts affected this month can be found in the Reader Aids section at the end of this issue.

# Rules and Regulations

Federal Register
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Tuesday, September 3, 1985



## ADMINISTRATIVE COMMITTEE OF THE FEDERAL REGISTER

### 1 CFR Part 3

### Price Increases for the Code of Federal Regulations and the Weekly Compilation of Presidential Documents

**AGENCY:** Administrative Committee of the Federal Register.

**ACTION:** Final rule.

**SUMMARY:** The Administrative Committee of the Federal Register (ACFR) announces price increases for annual Subscriptions to the paper edition of the Code of Federal Regulations (CFR) and to the Weekly Compilation of Presidential Documents. These increases are necessary to recover production and distribution costs to the Government.

**EFFECTIVE DATES:** Code of Federal Regulations prices, § 3.4(b)(4)—Jan. 1, 1986.

Weekly Compilation of Presidential Documents prices, § 3.4(b)(7)—October 1, 1985.

**FOR FURTHER INFORMATION CONTACT:** Frances D. McDonald, (202) 523–4534.

**SUPPLEMENTARY INFORMATION:** The ACFR which establishes prices for Federal Register publications has determined that the annual subscription for the 50 Titles of the CFR in paper edition will be $595 beginning with the 1986 edition. The annual subscription of the Weekly Compilation of Presidential Documents will be $84. These increases are necessary to recover production and distribution costs to the Government.

This is not a major rule under E.O. 12291. The Regulatory Flexibility Act (5 U.S.C. 601 et seq.) does not apply to these changes because they do not constitute a rule as defined by the Act nor do they necessitate a notice of proposed rulemaking.

**List of Subjects in 1 CFR Part 3**

Government publications, Federal Register publications, Subscription rates.

For the reasons set out in the preamble and under the authority given the Administrative Committee of the Federal Register by 44 U.S.C. 1506, Part 3 of Chapter I of Title 1 of the Code of Federal Regulations is amended as follows:

### PART 3—SERVICES TO THE PUBLIC

1. The authority citation for Part 3 continues to read as follows:

**Authority:** 44 U.S.C. 1506; sec. 6, E.O. 10530, 19 FR 2709; 3 CFR 1954–1958 Comp., p. 189.

2. Section 3.4 is amended by revising paragraphs (b)(4) and (7) to read as follows:

**§ 3.4 Subscriptions and Availability of Federal Register Publications.**

* * * * *

(b) * * *

(4) *Code of Federal Regulations.* A complete set will be furnished by mail to subscribers for $595 per year for the bound, paper edition, or for $185 per year for the microfiche edition. Subscription fees are payable in advance to the Superintendent of Documents. Individual copies of the Code volumes are sold by the Superintendent of Documents at prices determined by the Superintendent under the general direction of the Administrative Committee. The price of an individual volume in microfiche is $3.75.

* * * * *

(7) *Weekly Compilation of Presidential Documents*—(i) *Nonpriority mailing.* Issues will be furnished by mail to subscribers for $84 in advance to the Superintendent of Documents, Government Printing Office.

(ii) *First-class mailing.* Issues will be furnished to subscribers by first-class mail for $105 per year payable in advance to the Superintendent of Documents, Government Printing Office. Individual issues may be obtained for $1.75 per copy from the Superintendent of Documents, Government Printing Office.

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Approved:
**Frank G. Burke,**
*Acting Chairman.*
**Ralph Kennickell,**
*Member.*
**Ralph Tarr,**
*Member.*
**Edwin Meese III,**
*Attorney General.*
**Frank G. Burke,**
*Acting Archivist of the United States.*

[FR Doc. 85–21047 Filed 8–29–85; 3:21 pm]
BILLING CODE 1505-02-M

## DEPARTMENT OF AGRICULTURE

### Animal and Plant Health Inspection Service

### 7 CFR Part 319

**[Docket No. 85–354]**

### Unshu Oranges From Japan

**AGENCY:** Animal and Plant Health Inspection Service, USDA.

**ACTION:** Interim rule.

**SUMMARY:** Prior to the effective date of this document, the citrus fruit regulations prohibited Unshu oranges from being imported from Japan into the United States unless, among other things, (1) the Unshu oranges were imported by the United States Department of Agriculture for experimental or scientific purposes under certain conditions; (2) the Unshu oranges met certain stringent safeguards concerning growing, packing, inspection, treatment, labeling, and certification; and were imported into Alaska, Hawaii, Oregon, or Washington at certain ports and were destined to places in these States or to places in Idaho or Montana; or (3) the Unshu oranges were imported from Japan into Alaska for consumption there. This document removes the provisions referred to in item (3). Consequently, Unshu oranges are now prohibited from being imported from Japan into Alaska unless, among other things, they meet the provisions referred to above in item (2) or are imported by the United States Department of Agriculture for experimental or scientific purposes. This action is necessary to help prevent the dissemination of citrus canker in the United States.

**DATES:** Effective date of the interim rule: September 3, 1985. Written comments concerning this interim rule must be received on or before November 4, 1985.

**ADDRESSES:** Written comments should be submitted to Thomas O. Gessel, Director, Regulatory Coordination Staff, Animal and Plant Health Inspection Service, U.S. Department of Agriculture, Room 728, Federal Building, Hyattsville, MD 20782. Comments should state that they are in response to Docket Number 85–354. Written comments received may be inspected at Room 728 of the Federal Building between 8 a.m. and 4:30 p.m., Monday through Friday, except holidays.

**FOR FURTHER INFORMATION CONTACT:** Frank Cooper, Staff Officer, Regulatory Services Staff, Plant Protection and Quarantine, Animal and Plant Health Inspection Service, U.S. Department of Agriculture, Room 637, Federal Building, 6505 Belcrest Road, Hyattsville, MD 20782, 301–436–8248.

**SUPPLEMENTARY INFORMATION:**

### Emergency Action

Harvey L. Ford, Deputy Administrator of the Animal and Plant Health Inspection Service for Plant Protection and Quarantine, has determined that an emergency situation exists which warrants publication without prior opportunity for a public comment period on this interim rule. Because of the possibility that citrus canker could be spread artificially to noninfested areas of the United States, a situation exists requiring immediate action to better control the spread of this pest.

Further, pursuant to the administrative procedure provisions of 5 U.S.C. 553, it is found upon good cause that prior notice and public procedures with respect to this interim rule are impracticable and contrary to the public interest; and good cause is found for making this interim rule effective less than 30 days after publication of this document in the **Federal Register.** Comments are being solicited for 60 days after publication of this document, and a final document discussing comments received and any amendments requiring will be published in the **Federal Register** as soon as possible.

### Background

The importation of Unshu oranges, *Citrus reticulata* Blanco var. *Unshu* (this is a kind of tangerine and is also known as satsuma), from Japan into the United States is regulated under the citrus fruit regulations (7 CFR 319.28) and the fruits and vegetables regulations (7 CFR 319.56 *et seq.*). This document amends the citrus fruit regulations concerning the importation of Unshu oranges from Japan into Alaska. This document does not affect the fruits and vegetables regulations which prohibit the importation of Unshu oranges into the United States unless also imported in accordance with permit and other requirements.

The citrus fruit regulations were established for the purpose of preventing the introduction of citrus canker into the United States. Citrus canker is a disease which affects citrus. It is caused by the infectious bacterium *Xanthomonas campestris* pv. *citri* (Hasse 1915) Dye 1976. The disease in Japan infects the twigs, leaves, and fruit of a wide spectrum of commercial and noncommercial *Citrus* species.

Prior to the effective date of this document, the citrus fruit regulations prohibited Unshu oranges from being imported from Japan into the United States unless, among other things, (1) the Unshu oranges were imported by the United States Department of Agriculture for experimental or scientific purposes under certain conditions; (2) the Unshu oranges met certain stringent safeguards concerning growing, packing, inspection, treatment, labeling, and certification; and were imported into Alaska, Hawaii, Oregon, or Washington at certain ports and were destined to places in these States or to places in Idaho or Montana; or (3) the Unshu oranges were imported from Japan into Alaska for consumption there. This document removes the provisions referred to in item (3). Consequently, under the citrus fruit regulations, Unshu oranges are now prohibited from being imported from Japan into Alaska unless, among other things, they meet the provisions referred to above in item (2) or are imported by the United States Department of Agriculture for experimental or scientific purposes. This action is necessary to help prevent the dissemination of citrus canker in the United States.

Based on experience, it appears that all Unshu oranges that have been imported from Japan into Alaska during the past several years have been imported in accordance with the provisions of item (3) and have not been imported in compliance with the more stringent provisions referred to above in item (2). There is a small but significant risk that these Unshu oranges imported into Alaska could be infected or contaminated with citrus canker. Further, the provisions referred to in item (3) were established based on the assumption that the oranges would be consumed only in Alaska and would never be taken from Alaska to other parts of the United States where they could possibly cause an infestation of citrus canker. However, based on inspections, the Department has recently become aware of a number of movements of Unshu oranges from Alaska to other places in the United States. Further, there is a risk that some of the Unshu oranges imported from Japan into Alaska could be taken to other parts of the United States without being detected.

Under these circumstances, this document, on an emergency basis, removes the provisions referred to in item (3) above. Consequently, Unshu oranges are now prohibited from being imported from Japan into Alaska unless, among other things, they meet the provisions referred to in item (2) above, or are imported by the United States Department of Agriculture for experimental or scientific purposes.

### Executive Order 12291 and Regulatory Flexibility Act

This interim rule is issued in conformance with Executive Order 12291 and has been determined to be not a "major rule." Based on information compiled by the Department, it has been determined that this interim rule will have an annual effect on the economy of less than $100,000,000; will not cause a major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; and will not cause significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of the United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

The importation of Unshu oranges from Japan into Alaska represents an insignificant portion of all tangerines imported into the United States.

Under the circumstances, the Administrator of the Animal and Plant Health Inspection Service has determined that this action will not have a significant economic impact on a substantial number of small entities in the import or domestic tangerine market.

### Executive Order 12372

This program/activity is listed in the Catalog of Federal Domestic Assistance under No. 10.025 and is subject to the provisions of Executive Order 12372 which requires intergovernmental consultation with State and local officials. (See 7 CFR Part 3015, Subpart V, 48 FR 29112, June 24, 1983 40 FR 22675, May 31, 1984; 50 FR 14088, April 10, 1985.)

**List of Subjects in 7 CFR Part 319**

Agricultural Commodities, Citrus Canker, Imports, Plant diseases, Plant pests, Plant (Agriculture), Quarantine, Transportation.

**PART 319—[AMENDED]**

Under the circumstances referred to above Subpart—Citrus Fruit (7 CFR 319.28) is amended as follows:

1. The authority citation for 7 CFR Part 319 is revised to read as follows:

Authority: 7 U.S.C. 150dd, 150ee, 150ff, 151–167; 7 CFR 2.17, 2.51, and 371.2(c).

**§ 319.28 [Amended]**

2. In § 319.28, paragraph (h) is removed.

Done in Washington, D.C., this 27th day of August 1985.

Harvey L. Ford,

*Deputy Administrator, Plant Protection and Quarantine, Animal and Plant Health Inspection Service.*

[FR Doc. 85–20909 Filed 8–30–85; 8:45 am]

BILLING CODE 3410–34–M

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**Agricultural Stabilization and Conservation Service**

**7 CFR Part 736**

**[Amdt. No. 1]**

**Grain Warehouses; Inspection Fees**

*Correction*

In FR Doc. 85–20235 beginning on page 34075 in the issue of Friday, August 23, 1985, on page 34076, second column, in the Annual Fee Table, the last entry in the first column should read, "10,000,001 +".

BILLING CODE 1505–01–M

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**DEPARTMENT OF TRANSPORTATION**

**Federal Aviation Administration**

**14 CFR Part 108**

**[Docket No. 24719; Amdt. No. 108–3]**

**Aviation Security; Coordination and Training**

*Correction*

In FR Doc. 85–16867, beginning on page 28892, in the issue of Tuesday, July 16, 1985, make the following correction: On page 28894, §108.27, first line, "Administration" should read "Administrator".

BILLING CODE 1505–01–M

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**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Food and Drug Administration**

**21 CFR Part 177**

**[Docket No. 83F–0248]**

**Indirect Food Additives; Polymers; Polyetherimide Resin; Correction**

**AGENCY:** Food and Drug Administration.

**ACTION:** Final rule; correction.

**SUMMARY:** The Food and Drug Administration (FDA) is correcting the final rule that amended the food additive regulations to provide for the safe use of polyetherimide resin for use in contact with food (50 FR 31350; August 2, 1985). This document corrects the section number to place it in the proper subpart.

**EFFECTIVE DATE:** August 2, 1985.

**FOR FURTHER INFORMATION CONTACT:** Agnes B. Black, Regulations Editorial Staff (HFC–222), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301–443–2994.

**SUPPLEMENTARY INFORMATION:** In FR Doc. 85–18350 appearing in the Federal Register of August 2, 1985, the following changes are made on page 31351 in the left column:

1. Amendment No. 2 is corrected to read "2. By adding to Subpart B new § 177.1595 to read as follows:"

2. "§ 177.2425 *Polyetherimide resin.*" is corrected to read "§ 177.1595 *Polyetherimide resin.*"

Dated: August 22, 1985.

John M. Taylor,

*Acting Director, Center for Food Safety and Applied Nutrition.*

[FR Doc. 85–20895 Filed 8–30–85; 8:45 am]

BILLING CODE 4160–01–M

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**21 CFR Part 510**

**Animal Drugs, Feeds, and Related Products; Change of Sponsor Address**

**AGENCY:** Food and Drug Administration.

**ACTION:** Final rule.

**SUMMARY:** The Food and Drug Administration (FDA) is amending the animal drug regulations to reflect the current mailing address of Central Soya Co., Inc.

**EFFECTIVE DATE:** September 3, 1985.

**FOR FURTHER INFORMATION CONTACT:** David L. Gordon, Center for Veterinary Medicine (HFV–238), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301–443–6243.

**SUPPLEMENTARY INFORMATION:** Central Soya Co., Inc., P.O. Box 1400, Fort Wayne, IN 46801–1400, has advised FDA of its new mailing address. The agency is amending the files and the animal drug regulations to reflect the revised address.

**List of Subjects in 21 CFR Part 510**

Administrative practice and procedure, Animal drugs, Labeling, Reporting requirements.

Therefore, under the Federal Food, Drug, and Cosmetic Act and under authority delegated to the Commissioner of Food and Drugs and redelegated to the Center for Veterinary Medicine, Part 510 is amended as follows:

**PART 510—NEW ANIMAL DRUGS**

1. The authority citation for 21 CFR Part 510 continues to read as follows:

Authority: Secs. 512, 701(a), 52 Stat. 1055, 82 Stat. 343–351 (21 U.S.C. 360b, 371(a)); 21 CFR 5.10 and 5.83.

**§ 510.600 [Amended]**

2. Section 510.600 *Names, addresses, and drug labeler codes of sponsors of approved applications* is amended in paragraph (c)(1) in the entry for "Central Soya Co., Inc." and in paragraph (c)(2) in the entry "012286" by revising the sponsor's address to read "P.O. Box 1400, Fort Wayne, IN 46801–1400."

Dated: August 28, 1985.

Marvin A. Norcross,

*Acting Associate Director for Scientific Evaluation.*

[FR Doc. 85–20899 Filed 8–30–85; 8:45 am]

BILLING CODE 4160–01–M

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**21 CFR Part 558**

**New Animal Drugs For Use in Animal Feeds; Tylosin**

**AGENCY:** Food and Drug Administration.

**ACTION:** Final rule.

**SUMMARY:** The Food and Drug Administration (FDA) is amending the animal drug regulations to reflect approval of a supplemental new animal drug application (NADA) filed for I.M.S., Inc., providing for the manufacture of 5- and 10-gram-per-pound tylosin premixes, in addition to currently approved 20- and 40-gram-per-pound tylosin premixes, to make complete feeds for swine, beef cattle, and chickens.

**EFFECTIVE DATE:** September 3, 1985.

**FOR FURTHER INFORMATION CONTACT:** Benjamin A. Puyot, Center for Veterinary Medicine (HFV–135), Food

and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301–443–1414.

**SUPPLEMENTARY INFORMATION:** I.M.S., Inc., 13619 Industrial Rd., Omaha, NE 68137, is the sponsor of a supplement to NADA 127–195 submitted on its behalf by Elanco Products Co. The supplement provides for the manufacture of a new 5-gram-per-pound tylosin 85–516 premix to make complete feeds for swine, beef cattle, and chickens for use as in 21 CFR 558.625(f)(1) (i) through (vi). The use of the currently approved 10-gram-per-pound premix is revised to include additional uses in swine, and use in beef cattle and chickens. I.M.S. had previously received approval for 20- and 40-gram-per-pound tylosin premixes used to make complete swine, beef cattle, and chicken feeds. The supplement is approved and the regulations are amended to reflect the approval.

In accordance with the freedom of information provisions of Part 20 (21 CFR Part 20) and § 514.11(e)(2)(ii) (21 CFR 514.11(e)(2)(ii)), a summary of safety and effectiveness data and information submitted to support approval of this application may be seen in the Dockets Management Branch (HFA–305), Food and Drug Administration, Rm. 4–62, 5600 Fishers Lane, Rockville, MD 20857, from 9 a.m. to 4 p.m., Monday through Friday.

The agency has determined under 21 CFR 25.24(d)(1)(i) (April 26, 1985; 50 FR 16636) that this action is of a type that does not individually or cumulatively have a significant effect on the human environment. Therefore, neither an environmental assessment nor an environmental impact statement is required.

**List of Subjects in 21 CFR Part 558**

Animal drugs, Animal feeds.

Therefore, under the Federal Food, Drug, and Cosmetic Act and under authority delegated to the Commissioner of Food and Drugs and redelegated to the Center for Veterinary Medicine, Part 558 is amended as follows:

## PART 558—NEW ANIMAL DRUGS FOR USE IN ANIMAL FEEDS

1. The authority citation for 21 CFR Part 558 continues to read as follows:

**Authority:** Sec. 512, 82 Stat. 343–351 (21 U.S.C. 360b); 21 CFR 5.10 and 5.83.

2. In § 558.625 by revising paragraph (b)(77) to read as follows:

**§ 558.625 Tylosin.**

* * * * *

(b) * * *

(77) To 050639: 5, 10, 20, and 40 grams per pound, paragraph (f)(1)(i) through (vi) of this section.

* * * * *

Dated: August 26, 1985.

**Marvin A. Norcross,**

*Acting Associate Director for Scientific Evaluation.*

[FR Doc. 85–20898 Filed 8–30–85; 8:45 am]

BILLING CODE 4160–01–M

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**21 CFR Part 558**

### New Animal Drugs For Use in Animal Feeds; Tylosin

**AGENCY:** Food and Drug Administration.

**ACTION:** Final rule.

**SUMMARY:** The Food and Drug Administration (FDA) is amending the animal drug regulations to reflect approval of a supplemental new animal drug application (NADA) filed for MAC-PAGE, Inc., providing for the manufacture of 5- and 20-gram-per-pound tylosin premixes, in addition to its currently approved 10- and 40-gram-per-pound tylosin premixes, used to make finished feeds for swine, beef cattle, and chickens.

**EFFECTIVE DATE:** September 3, 1985.

**FOR FURTHER INFORMATION CONTACT:** Benjamin A. Puyot, Center for Veterinary Medicine (HFV–135), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301–443–1414.

**SUPPLEMENTARY INFORMATION:** MAC-PAGE, Inc., 1600 South Wilson Ave., Dunn, NC 28334, is the sponsor of supplemental NADA 131–957 submitted on its behalf by Elanco Products Co. The supplement provides for the manufacture of 5- and 20-gram-per-pound tylosin premixes to subsequently make finished feeds for swine, beef cattle, and chickens for use as in 21 CFR 558.625(f)(1)(i) through (vi). The firm currently holds approval for manufacturing 10- and 40-gram-per-pound tylosin premixes. The supplemental NADA is approved and the regulations are amended to reflect the approval.

In accordance with the freedom of information provisions of Part 20 (21 CFR Part 20) and § 514.11(e)(2)(ii) (21 CFR 514.11(e)(2)(ii)), a summary of safety and effectiveness data and information submitted to support approval of this application may be seen in the Dockets Management Branch (HFA–305), Food and Drug Administration, Rm. 4–62, 5600 Fishers Lane, Rockville, MD 20857, from 9 a.m. to 4 p.m., Monday through Friday.

The agency has determined under 21 CFR 25.24(d)(1)(i) (April 26, 1985; 50 FR 16636) that this action is of a type that does not individually or cumulatively have a significant effect on the human environment. Therefore, neither an environmental assessment nor an environmental impact statement is required.

**List of Subjects in 21 CFR Part 558**

Animal drugs, Animal feeds.

Therefore, under the Federal Food, Drug, and Cosmetic Act and under authority delegated to the Commissioner of Food and Drugs and redelegated to the Center for Veterinary Medicine, Part 558 is amended as follows:

## PART 558—NEW ANIMAL DRUGS FOR USE IN ANIMAL FEEDS

1. The authority citation for 21 CFR Part 558 continues to read as follows:

**Authority:** Sec. 512, 82 Stat. 343–351 (21 U.S.C. 360b); 21 CFR 5.10 and 5.83.

2. Section 558.625 is amended by revising paragraph (b)(79) to read as follows:

**§ 558.625 Tylosin.**

* * * * *

(b) * * *

(79) To 047427: 5, 10, 20, and 40 grams per pound, paragraph (f)(1)(i) through (vi) of this section.

* * * * *

Dated: August 26, 1985.

**Marvin A. Norcross,**

*Acting Associate Director for Scientific Evaluation.*

[FR Doc. 85–20900 Filed 8–30–85; 8:45 am]

BILLING CODE 4160–01–M

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## DEPARTMENT OF THE TREASURY

### Internal Revenue Service

### 26 CFR Parts 1 and 602

**[T.D. 8048]**

### Income Tax; Information Reporting for Mortgage Credit Certificates

**AGENCY:** Internal Revenue Service, Treasury.

**ACTION:** Temporary regulations.

**SUMMARY:** This document contains temporary regulations that relate to mortgage credit certificates. Changes to the applicable tax law were made by the Tax Reform Act of 1984. These regulations affect all holders and issuers of mortgage credit certificates. In addition, the text contained in the temporary regulations set forth in this

document serves as the text of the proposed regulations cross-referenced in the notice of proposed rulemaking in the Proposed Rules section of this issue of the **Federal Register.**

**DATES:** These regulations are effective September 3, 1985 and are applicable to mortgage credit certificates issued after September 30, 1985.

**FOR FURTHER INFORMATION CONTACT:** Mitchell H. Rapaport of the Legislation and Regulations Division, Office of Chief Counsel, Internal Revenue Service, 1111 Constitution Avenue, NW., Washington, DC 20224 (Attention: CC:LR:T) (202–566–3740).

**SUPPLEMENTARY INFORMATION:**

**Background**

This document contains amendments to the temporary regulations relating to mortgage credit certificates under section 25 of the Internal Revenue Code of 1954 as amended by section 612 of the Tax Reform Act of 1984 (Pub. L. 98–369; 98 Stat. 905). The temporary regulations provided by this document will remain in effect until superseded by final regulations on this subject.

**Explanation of Provisions**

Section 25 authorizes States and political subdivisions ("issuers") to issue mortgage credit certificates ("MCCs") in lieu of qualified mortgage bonds. MCCs entitle qualifying individuals to a credit against the individuals' Federal income tax. The amount of the credit is determined by multiplying the certificate credit rate by the amount of interest paid or accrued by the taxpayer during the taxpayer's taxable year on the certified indebtedness amount. In order for an individual to claim the credit provided by section 25, the MCC must be a "qualified mortgate credit certificate" issued pursuant to a "qualified mortgage credit certificate program". The requirements of section 103A(j), including the State certification requirement, the policy statement requirement, and the information reporting requirement, must be met in order for a program to be a qualified mortgage credit certificate program.

On May 8, 1985, temporary and proposed regulations with respect to MCCs were published in the **Federal Register** (50 FR 19344; 50 FR 19383). Those regulations reserved § 1.25–4T(e), relating to the information reporting requirement, and § 1.25–4T(f), relating to the policy statement requirement. The Service received numerous written comments responding to a notice of proposed rulemaking published in the **Federal Register** on December 12, 1984 (49 FR 48323), with respect to the reporting and policy statement requirements as they apply to qualified mortgage bonds and qualified veterans' mortgage bonds, and a public hearing was held on April 30, 1985. After consideration of all comments regarding those proposed regulations, temporary and proposed regulations relating to the information reporting and policy statement requirements applicable to mortgage credit certificates are being provided. The proposed regulations are published elsewhere in this issue.

Section 1.25–4T (e) contains the information reporting requirements applicable to issuers of mortgage credit certificates. This requirement must be satisfied for a program to be a qualified mortgage credit certificate program. In order to satisfy the information reporting requirement, an issuer must submit a report concerning the holders of certificates issued during the relevant reporting period. The information required to be submitted is to be presented in tabular form. Section 1.25–4T(e)(1)(i) requires the submission of information concerning the number of mortgage credit certificates categorized according to the income of the holders and the acquisition cost of the residences; this information is to be further categorized according to whether the holders had no present ownership interest in their principal residences at any time during the 3-year period ending on the date the MCC is executed (*i.e.*, satisfy the 3-year requirement) and whether the residences are located in targeted areas. In addition, information concerning the fees charged to the holders must be submitted. Section 1.25–4T(e)(1)(ii) requires the submission of information concerning the volume of MCCs (*i.e.*, the total of the certified indebtedness amount of the certificates issued and the sum of the products of the certified indebtedness amount and the certificate credit rate for each certificate) according to the income of the holders and the acquisition cost of the residences; this information is also to be categorized according to whether the holders satisfy the 3-year requirement and whether the residences are located in targeted areas. With respect to home improvement and rehabilitation loans, § 1.25–4T(e)(1)(iii) requires the submission of information concerning the number and volume of such loans categorized according to whether the residences are located in targeted areas.

Section 1.25–4T(f) contains the policy statement requirement. In order for a program to be a qualified mortgage credit certificate program, the applicable elected representative of the governmental unit which is the issuer (or on whose behalf the certificates were issued) must have published (after a public hearing following reasonable public notice) a policy statement by the last day of the year preceding the year in which the election not to issue qualified mortgage bonds was made, and the representative must have submitted a copy of the policy statement to the Commissioner. The provisions concerning the policy statement that must be submitted by issuers of MCCs are identical to those applicable to issuers of qualified mortgage bonds. See § 1.103A–2(1).

**Non-Applicability of Executive Order 12291**

The Commissioner of Internal Revenue has determined that this proposed rule is not a major rule as defined in Executive Order 12291 and that a regulatory impact analysis therefore is not required.

**Regulatory Flexibility Analysis**

A general notice of proposed rulemaking is not required by 5 U.S.C. 553 for temporary regulations. Accordingly, the temporary regulations do not constitute regulations subject to the Regulatory Flexibility Act (5 U.S.C. chapter 6).

**Paperwork Reduction Act**

The collection of information requirements contained in these regulations have been submitted to the Office of Management and Budget in accordance with the requirements of the Paperwork Reduction Act of 1980. These requirements have been approved by the OMB under control number 1545–0922.

**Drafting Information**

The principal author of these proposed regulations is Mitchell H. Rapaport of the Legislation and Regulations Division of the Office of Chief Counsel, Internal Revenue Service. However, personnel from other offices of the Internal Revenue Service and Treasury Department participated in developing the regulations, on matters of both substance and style.

**List of Subjects**

*26 CFR 1.0–1—1.58–8*

Income taxes, Tax liability, Tax rates, Credits.

**List of Subjects**

*26 CFR Part 602*

Reporting and recordkeeping requirements.

**Amendments to the Regulations**

For the reasons set out in the preamble, Part 1 and Part 602 of Title 26

of the Code of Federal Regulations are amended as follows:

## PART 1—INCOME TAX REGULATIONS

**Paragraph 1.** The authority for Part 1 continues to read in part:

Authority: 26 U.S.C. 7805. * * * Section 1.25–4T also issued under 26 U.S.C. 25(g). * * *

**Par. 2.** The text of paragraphs (e) and (f) of § 1.25–4T is added to read as follows:

**§ 1.25–4T Qualified mortgage credit certificate program.**

* * * * *

(e) *Information reporting requirement*—(1) *Reports.* With respect to mortgage credit certificates issued after September 30, 1985, a program meets the requirements of this paragraph only if the issuer submits a report containing the information concerning the holders of certificates issued during the preceding reporting period required by this paragraph. The report must be filed for each reporting period in which certificates (other than transferred certificates) are issued under the program. The issuer is not responsible for false information provided by a holder if the issuer did not know or have reason to know that the information was false. The report must be filed on the form prescribed by the Internal Revenue Service. If no form is prescribed, or if the form prescribed is not readily available, the issuer may use its own form provided that such form is in the format set forth in this paragraph and contains the information required by this paragraph. The report must be titled "Mortgage Credit Certificate Information Report" and must include the name, address, and TIN of the issuer, the reporting period for which the information is provided, and the following tables containing information concerning the holders of certificates issued during the reporting period for which the report is filed:

(i) A table titled "Number of Mortgage Credit Certificates by Income and Acquisition Cost" showing the number of mortgage credit certificates issued (other than those issued in connection with qualified home improvement and rehabilitation loans) according to the annualized gross income of the holders (categorized in the following intervals of income: $0–$9,999; $10,000–$19,999; $20,000–$29,999; $30,000–$39,999; $40,000–$49,999; $50,000–$74,999; and $75,000 or more) and according to the acquisition cost of the residences acquired in connection with the mortgage credit certificates (categorized in the following intervals of acquisition cost: $0–$19,999; $20,000–$39,999; $40,000–$59,999; $60,000–$79,999; $80,000–$99,999; $100,000–$119,999; $120,000–$149,999; $150,000–$199,999; and $200,000 or more). For each interval of income and acquisition cost the table must also be categorized according to—

(A) The aggregate amount of fees charged to holders to cover any administrative costs incurred by the issuer in issuing mortgage credit certificates, and

(B) The number of holders that—

(*1*) Did not have a present ownership interest in a principal residence at any time during the 3-year period ending on the date the mortgage credit certificate is executed (*i.e.*, satisfied the 3-year requirement) and purchased residences in targeted areas,

(*2*) Satisfied the 3-year requirement and purchased residences not located in targeted areas,

(*3*) Did have a present ownership interest in a principal residence at any time during the 3-year period ending on the date the mortgage credit certificate is executed (*i.e.*, did not satisfy the 3-year requirement) and purchased residences in targeted areas, and

(*4*) Did not satisfy the 3-year requirement and purchased residences not located in targeted areas.

(ii) A table titled "Volume of Mortgage Credit Certificates by Income and Acquisition Cost" containing data on—

(A) The total of the certified indebtedness amounts of the certificates issued (other than those issued in connection with qualified home improvement and rehabilitation loans);

(B) The sum of the products of the certified indebtedness amount and the certificate credit rate for each certificate (other than those issued in connection with qualified home improvement and rehabilitation loans) according to annualized gross income (categorized in the same intervals of income as the preceding table) and according to the acquisition cost of the residences acquired in connection with mortgage credit certificates (categorized in the same intervals of acquisition cost as the preceding table); and

(C) For each interval of income and acquisition cost, the information described in paragraph (e)(1)(ii) (A) and (B) categorized according to the holders that—

(*1*) Satisfied the 3-year requirement and purchased residences in targeted areas,

(*2*) Satisfied the 3-year requirement and purchased residences not located in targeted areas,

(*3*) Did not satisfy the 3-year requirement and purchased residences in targeted areas, and

(*4*) Did not satisfy the 3-year requirement and purchased residences not located in targeted areas.

(iii) A table titled "Mortgage Credit Certificates for Qualified Home Improvement and Rehabilitation Loans" showing the number of mortgage credit certificates issued in connection with qualified home improvement loans and qualified rehabilitation loans, the total of the certified indebtedness amount with respect to such certificates, and the sum of the products of the certified indebtedness amount and the certificate credit rate for each certificate; the information contained in the table must also be categorized according to whether the residences with respect to which the certificates were provided are located in targeted areas.

(2) *Format.* If no form is prescribed by the Internal Revenue Service, or if the prescribed form is not readily available, the issuer must submit the report in the format specified in this paragraph (e)(2). The specified format of the report is the following:

**Mortgage Credit Certificate Information Report**

Name of issuer:
Address of issuer:
TIN of issuer:
Reporting period:

NUMBER OF MORTGAGE CREDIT CERTIFICATES BY INCOME AND ACQUISITION COST

| 3-year requirement: Annualized gross monthly income of borrowers | Satisfied | | Not satisfied | | Totals fees |
|---|---|---|---|---|---|
| | Nontargeted area | Targeted area | Nontargeted area | Targeted area | |
| $0 to $9,999 | | | | | |
| $10,000 to $19,999 | | | | | |
| $20,000 to $29,999 | | | | | |
| $30,000 to $39,999 | | | | | |
| $40,000 to $49,999 | | | | | |
| $50,000 to $74,999 | | | | | |
| $75,000 or more | | | | | |
| Total | | | | | |
| Acquisition Cost | | | | | |
| 0 to $19,999 | | | | | |
| $20,000 to $39,999 | | | | | |
| $40,000 to $59,999 | | | | | |
| $60,000 to $79,999 | | | | | |
| $80,000 to $99,999 | | | | | |
| $100,000 to $119,999 | | | | | |
| $120,000 to $149,999 | | | | | |
| $150,000 to $199,999 | | | | | |
| $200,000 or more | | | | | |
| Total | | | | | |

VOLUME OF MORTGAGE CREDIT CERTIFICATES BY INCOME AND ACQUISITION COST

| Annualized gross monthly income of holders | Holders satisfying the 3-year requirement | | | | 3-year requirement not satisfied | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Nontargeted area | | Targeted area | | Nontargeted area | | Targeted area | | | |
| | Total of the certified indebtedness amounts | Sum of products of certified indebtedness amounts and credit rates | Total of the certified indebtedness amounts | Sum of products of certified indebtedness amounts and credit rates | Total of the certified indebtedness amounts | Sum of products of certified indebtedness amounts and credit rates | Total of the certified indebtedness amounts | Sum of products of certified indebtedness amounts and credit rates | Total of the certified indebtedness amounts | Total sum of products of certified indebtedness amounts and credit rates |
| $0 to $9,999 | | | | | | | | | | |
| $10,000 to $19,999 | | | | | | | | | | |
| $20,000 to $29,999 | | | | | | | | | | |
| $30,000 to $39,999 | | | | | | | | | | |
| $40,000 to $49,999 | | | | | | | | | | |
| $50,000 to $74,999 | | | | | | | | | | |
| $75,000 to more | | | | | | | | | | |
| Total | | | | | | | | | | |
| Acquisition Cost | | | | | | | | | | |
| $0 to $19,999 | | | | | | | | | | |
| $20,000 to $39,999 | | | | | | | | | | |
| $40,000 to $59,999 | | | | | | | | | | |
| $60,000 to $79,999 | | | | | | | | | | |
| $80,000 to $99,999 | | | | | | | | | | |
| $100,000 to $119,999 | | | | | | | | | | |
| $120,000 to $149,999 | | | | | | | | | | |
| $150,000 to $199,999 | | | | | | | | | | |
| $200,000 or more | | | | | | | | | | |
| Total | | | | | | | | | | |

MORTGAGE CREDIT CERTIFICATES FOR QUALIFIED HOME IMPROVEMENT AND REHABILITATION LOANS

| | Nontargeted area | Targeted area | Totals |
|---|---|---|---|
| Home Improvement Loans | | | |
| Number of mortgage credit certificates | | | |
| Total of the certified indebtedness amounts | | | |
| Product of certified indebtedness amounts and credit rates | | | |
| Rehabilitation Loans | | | |
| Number of mortgage credit certificates | | | |
| Total of the certified indebtedness amounts | | | |
| Product of certified indebtedness amounts and credit rates | | | |

(3) *Definitions and special rules.* (i) For purposes of this paragraph the term "annualized gross income" means the borrower's gross monthly income multiplied by 12. Gross monthly income is the sum of monthly gross pay, any additional income from investments, pensions, Veterans' Administration (VA) compensation, part-time employment, bonuses, dividends, interest, current overtime pay, net rental income, etc., and other income (such as alimony and child support, if the borrower chooses to disclose such income). Information with respect to gross monthly income may be obtained from available loan documents, *e.g.*, the sum of lines 23D and 23E on the Application for VA or FmHA Home Loan Guaranty or for HUD/FHA Insured Mortgage (VA Form 26–1802a, HUD 92900, Jan. 1982), or the total line from the Gross Monthly Income section of FHLMC Residential Loan Application form (FHLMC 65 Rev. 8/78).

(ii) For purposes of this paragraph, the term "reporting period" means each one year period beginning July 1 and ending June 30, except that issuers need not provide data with respect to the period prior to October 1, 1985.

(iii) For purposes of this paragraph, verification of information concerning a holder's gross monthly income by utilizing other available information concerning the holder's income (*e.g.*, Federal income tax returns) is not required. In determining whether the holder of a mortgage credit certificate acquiring a residence in a targeted area satisfies the 3-year requirement, the issuer may rely on a statement signed by the holder.

(4) *Time for filing.* The report required by this paragraph shall be filed not later than the 15th day of the second calendar month after the close of the reporting period. The Commissioner may grant an extension of time for the filing of a report required by this paragraph if there is reasonable cause for the failure to file such report in a timely fashion. The report may be filed at any time before such date but must be complete based on facts and reasonable expectations as of the date the report is filed. The report need not be amended to reflect information learned subsequent to the date of filing, or to reflect changed circumstances with respect to any holder.

(5) *Place for filing.* The report required by this paragraph is to be filed at the Internal Revenue Service Center, Philadelphia, Pennsylvania 19255.

(f) *Policy statement.* A program established pursuant to an election under paragraph (c) made after 1984 meets the requirements of this paragraph only if the applicable elected

representative of the governmental unit—

(1) Which is the issuer, or

(2) On whose behalf the certificates were issued,

has published (after a public hearing following reasonable public notice) a policy statement described in § 1.103A–2(1) by the last day of the year preceding the year in which the election under paragraph (c) is made, and a copy of such report has been submitted to the Commissioner on or before such last day. See § 1.103A–2(1) for further definitions and requirements.

* * * * *

## PART 602—OMB CONTROL NUMBERS UNDER THE PAPERWORK REDUCTION ACT

**Par. 3.** The authority citation for Part 602 continues to read as follows:

**Authority:** 26 U.S.C. 7805.

**Par. 4.** Section 602.101(c) is amended by inserting in the appropriate places in the table "§ 1.25–4T . . . . . 1545–0922".

There is a need for immediate guidance with respect to the provisions contained in this Treasury decision. For this reason it is found impracticable to issue it with notice and public procedure under subsection (b) of section 553 of title 5 of the United States Code or subject to the effective date limitation of subsection (d) of that section.

**James I. Owens,**

*Acting Commissioner of Internal Revenue.*

Approved: August 19, 1985.

**Ronald A. Pearlman,**

*Assistant Secretary of the Treasury.*

[FR Doc. 85–20969 Filed 8–29–85; 10:53 am]

BILLING CODE 4830–01–M

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**26 CFR Parts 1, 6a, and 602**

**[T.D. 8049]**

## Income Tax; Information Reporting for Mortgage Subsidy Bonds

**AGENCY:** Internal Revenue Service, Treasury.

**ACTION:** Final regulations.

**SUMMARY:** This document contains final regulations that relate to the tax exempt status of mortgage subsidy bonds. Changes to the applicable tax law were made by the Tax Reform Act of 1984. These regulations affect all purchasers, beneficiaries, and governmental issuers of tax exempt mortgage subsidy bonds.

**DATES:** These regulations are effective with respect to mortgage subsidy bonds issued after December 31, 1984, except that the regulations relating to qualified veterans' mortgage bonds (§ 1.103A–2(k)(5)(iv)) are effective for obligations issued after July 18, 1984.

**FOR FURTHER INFORMATION CONTACT:** Mitchell H. Rapaport of the Legislation and Regulations Division, Office of Chief Counsel, Internal Revenue Service, 1111 Constitution Avenue, NW., Washington, D.C. 20224 (Attention: CC:LR:T) (202–566–3740).

**SUPPLEMENTARY INFORMATION:**

### Background

On December 12, 1984, the Federal Register published proposed amendments to the Income Tax Regulations (26 CFR Part 1) under section 103A(j) (3), (4), and (5) of the Internal Revenue Code of 1954 (49 FR 48323). The amendments were, in part, proposed to conform the regulations to section 611(b) of the Tax Reform Act of 1984 (Pub. L. 98–369; 98 Stat. 901). A public hearing was held on April 30, 1985. After consideration of all comments regarding the proposed amendments, those amendments are adopted as revised by this Treasury decision. In addition, the regulations adopted by this Treasury decision supersede the temporary regulations under section 103A(j) (3), (4), and (5). Acccordingly, those portions of the Temporary Regulations under Title II of the Omnibus Reconciliation Act of 1980 relating to the changes made by section 611(b) of the Tax Reform Act are removed and replaced with a cross-reference to the rules adopted by this Treasury decision.

### Explanation of Provisions

Section 103(a) provides that gross income does not include interest on the obligations of a State or political subdivision thereof. Section 103A provides that any mortgage subsidy bond shall be treated as an obligation not described in section 103(a). However, qualified mortgage bonds and qualified veterans' mortgage bonds are not treated as mortgage subsidy bonds. Section 611 of the Tax Reform Act added several requirements to the definition of qualified mortgage bond and qualified veterans' mortgage bond.

### Public Comments

Many commentators objected to the extent of the information required to be reported with respect to each beneficiary of the proceeds of an issue (*i.e.*, each recipient of a mortgage loan provided with the proceeds of an issue). In response to these comments, the regulations have been revised to require the reporting of significantly less information. In addition, the regulations adopt the suggestion that information be reported on an aggregate basis, rather than with respect to each recipient of a mortgage loan. It is believed that information collected with respect to each recipient of a mortgage loan may be useful to the government in assessing the mortgage bond and mortgage credit certificate programs. Nevertheless, due to practical considerations, including the requirement of section 611(d)(7) of the Tax Reform Act of 1984, that the Secretary of the Treasury, in consultation with the Secretary of Housing and Urban Development, submit a report concerning these programs to Congress by January 1, 1987, it has been decided to require the reporting of data on an aggregate basis.

As revised, the regulations require information reporting with respect to the number of loans and aggregate principal amount of the loans categorized according to (1) the borrowers' income, (2) the acquisition cost of the residences acquired, (3) whether the borrowers have satisfied the 3-year requirement, and (4) whether the residences are located in targeted areas. With respect to qualified home improvement and rehabilitation loans, the only information required to be reported is the number and aggregate loan amount of such loans and whether the loans are with respect to residences located in targeted areas. Similar information is to be collected with respect to mortgage credit certificates. See § 1.25–4T(e). This information is being collected in response to section 611(d)(7) of the Tax Reform Act of 1984 which requires that the Secretary of the Treasury submit a report to Congress by January 1, 1987, regarding the performance of issuers of qualified mortgage bonds and mortgage credit certificates relative to the intent of Congress described in section 103A(j)(5).

Some commentators objected to the extent of information required to be reported with respect to qualified veterans' mortgage bonds on the grounds that such information is not relevant to qualified veterans' mortgage bonds because such bonds are not subject to all of the statutory requirements imposed on qualified mortgage bonds. Although information concerning income, acquisition cost, and the 3-year requirement is not relevant to any statutory requirement imposed on qualified veterans' mortgage bonds, the collection of such information pursuant to section 103A(j)(3)(A) is relevant to an evaluation of the qualified veterans' mortgage bond program. Accordingly, the final regulations require information reporting on qualified veterans' mortgage bonds with respect to the

number of loans and the aggregate principal amounts of the loans categorized according to (1) the borrowers' income, (2) the acquisition cost of the residences acquired, and (3) whether the borrowers have satisfied the 3-year requirement.

Several commentators stated that the regulations should be amended to make clear that the information required to be reported is information as of the date such information is required to be submitted and is not affected by later events. Similarly, it was suggested that the State certification requirement of section 103A(j)(4) should not require officials to certify as to matters that could change in the future. These suggestions have been adopted.

Commentators suggested that the information reporting requirement should apply only to mortgages provided with the original proceeds of an issue. This suggestion has been adopted. Thus, for example, reporting would not be necessary with respect to assumptions of mortgage loans.

Many commentators objected to the requirement that information be submitted on magnetic media. Accordingly, the regulations as revised do not require reporting on magnetic media.

A number of commentators stated that the regulations did not define the term "beneficiary" and that the regulations implied that it was necessary to file more than one report where, for example, a husband and a wife jointly obtain a mortgage. In addition, commentators stated that only the income of the borrower, and not the income of all the members of the borrower's family, is the relevant information for purposes of section 103A. Accordingly, the regulations have been revised to require reporting with respect to the "borrowers" of the original proceeds.

In response to public comments, the regulations no longer require data on borrower income to be collected under the definition used for purposes of section 8 of the Housing Act of 1937, as amended. Instead, annualized gross monthly income, as reported by borrowers on standard loan documents, is to be reported. In addition, issuers are not required to check the accuracy of information collected by examining borrowers' tax returns. Similarly, in determining whether a borrower acquiring a residence in a targeted area satisfies the 3-year requirement, the issuer may rely on a statement signed by the borrower.

Commentators indicated that issuers should not be responsible for submitting false information provided to them by mortgagors. This suggestion has been adopted.

A number of commentators stated that the regulations require excessive and redundant information to be included in the policy statement as described in section 103A(j)(5). In response to these comments, the regulations have been revised to make clear that the provisions describing the information to be included in the policy statement are intended merely as examples of the types of information that an issuer may include in its policy statement; thus, there is no requirement that all such information be provided. In addition, in response to comments, the definitions of "low", "moderate", and "median" income for purposes of providing information in the policy statement have been revised.

Several commentators stated that there is no statutory requirement that issuers indicate in the policy statement their "goals" with respect to housing, development, and low-income housing assistance. Accordingly, the regulations as revised do not require issuers to indicate their goals with respect to these matters.

The proposed regulations provided that issuers that did not issue qualified mortgage bonds in a particular year and did not reasonably expect to issue qualified mortgage bonds in the following year would not be precluded from issuing qualified mortgage bonds in the following year if a policy statement is filed prior to the date of issue. In response to public comments, the final regulations provide that this provision will apply if the issuer did not reasonably expect to issue qualified mortgage bonds during the following year, regardless of whether it issued bonds in the current year.

Commentators stated that the requirement that the notice of hearing summarize the policy statement is unnecessary and adds to the expense of providing such notice. In response to this comment, the regulations have been revised to require only that the notice contain a statement that the hearing will involve the issuer's policies with respect to housing, development, and low-income housing assistance which the issuer is to follow in issuing qualified mortgage bonds and mortgage credit certificates.

In response to public comments, the periods covered by the reports relating to the use of proceeds and the periods for assessing compliance with the statements of policy have been modified. In general, as modified, these periods end each year on June 30.

With respect to the State certification requirement, commentators stated that the rule permitting an issuer, after a 30 day waiting period, to self-certify that an issue satisfies the requirements of section 103A(g) requires too long a period of time to elapse before the issuer may execute this certification. In response to this comment, this rule has been modified so as to permit the issuer to execute this certification after 15 days.

In response to public comments, the regulations have been revised to make clear that the State certifications must be executed on or before the date of issue.

### Non-Applicability of Executive Order 12291

The Commissioner of Internal Revenue has determined that this proposed rule is not a major rule as defined in Executive Order 12291 and that a regulatory impact analysis therefore is not required.

### Regulatory Flexibility Analysis

Although a notice of proposed rulemaking that solicited public comment was issued, the Internal Revenue Service concluded when that notice was issued that the regulations are interpretative and that the notice and public procedure requirements of 5 U.S.C. 553 do not apply. Accordingly, the final regulations do not constitute regulations subject to the Regulatory Flexibility Act (5 U.S.C. chapter 6).

### Paperwork Reduction Act

The collection of information requirements contained in these regulations have been submitted to the Office of Management and Budget in accordance with the requirements of the Paperwork Reduction Act of 1980. These requirements have been approved by OMB under control number 1545-0720.

### Drafting Information

The principal author of these proposed regulations is Mitchell H. Rapaport of the Legislation and Regulations Division of the Office of Chief Counsel, Internal Revenue Service. However, personnel from other offices of the Internal Revenue Service and Treasury Department participated in developing the regulations, on matters of both substance and style.

### List of Subjects

*26 CFR Parts 1.61–1 through 1.281–4*

Income taxes, Taxable income, Deductions, Exemptions.

*26 CFR Part 6a*

Bonds, Income taxes, Mortgages, Veterans, Foreign investment in United States property interests.

*26 CFR Part 602*

Reporting and recordkeeping requirements.

**Amendments to the Regulations**

For the reasons set out in the preamble, Part 1, Part 6a, and Part 602 of Title 26 of the Code of Federal Regulations are amended as follows:

**PART 1—[AMENDED]**

**Paragraph 1.** The authority for Part 1 is amended by adding the following citation:

**Authority:** 26 U.S.C. 7805. * * * § 1.103A–2 (k), (l), and (m) also issued under 26 U.S.C. 103A(j) (3), (4), and (5). * * *

**Par. 2.** New § 1.103A–2 is added immediately following § 1.103(n)–7T to read as follows:

**§ 1.103A–2 Qualified mortgage bond.**

(a)–(j) [Reserved]

(k) *Information reporting requirement*—(1) *In general.* An issue meets the requirements of this paragraph only if the issuer in good faith attempted to meet the information reporting requirements of this paragraph. Except as otherwise provided in paragraph (k)(5)(iv) of this section, the requirements of this paragraph apply to qualified veterans' mortgage bonds issued after July 18, 1984, and to qualified mortgage bonds issued after December 31, 1984.

(2) *Information required.* (i) The issuer must, based on information and reasonable expectations determined as of the date of issue, submit on Form 8038 the information required therein; the issuer need not however, include the information required by Form 8038 that is relevant only to obligations described in section 103(l)(1) and the regulations thereunder. The information that must be submitted includes—

(A) The name, address, and employer identification number of the issuer,

(B) The date of issue,

(C) The face amount of each obligation which is part of the issue,

(D) The total purchase price of the issue,

(E) The amount allocated to a reasonably required reserve or replacement fund,

(F) The amount of lendable proceeds,

(G) The stated interest rate of each maturity,

(H) The term of each maturity,

(I) In the case of an issue of qualified mortgage bonds, whether the issuer has elected under § 6a.103A–2(i)(4)(v) to pay arbitrage to the United States,

(J) In the case of an issue of qualified mortgage bonds, the issuer's market limitation as of the date of issue (as defined in § 6a.103A–2(g)), the amount of qualified mortgage bonds that the issuer has elected not to issue under section 25(c)(2) and the regulations thereunder, and the aggregate amount of qualified mortgage bonds issued to date by the issuer during the calendar year, and

(K) In the case of an issue of qualified veterans' mortgage bonds, the issuer's State veterans limit (as defined in section 103A(o)(3)(B) and the regulations thereunder) and the aggregate amount of qualified veterans' mortgage bonds issued to date by the issuer during the calendar year and prior to the date of issue of the issue for which the Form 8038 is being submitted.

(ii) With respect to issues issued after December 31, 1984, the issuer must submit a report containing information on the borrowers of the original proceeds of such issues. The report must be filed for each reporting period in which the original proceeds of any of such issues are used to provide mortgages. The issuer is not responsible for false information provided by a borrower if the issuer did not know or have reason to know that the information was false. The report must be filed on the form prescribed by the Internal Revenue Service. If no form is prescribed, or if the form prescribed is not readily available, the issuer may use its own form provided that such form is in the format set forth in paragraph (k)(3) of this section and contains the information required by this paragraph (k)(2)(ii). The report must be titled "Qualified Mortgage Bond Information Report" or "Qualified Veterans' Mortgage Bond Information Report", and must include the name, address, and TIN of the issuer, the reporting period for which the information is provided, and the following tables containing information concerning the borrowers of the original proceeds of the issues subject to the requirements of this paragraph (k)(2)(ii) with respect to mortgages provided during the reporting period for which the report is filed:

(A) A table titled "Number of Mortgage Loans by Income and Acquisition Cost" showing the number of mortgage loans (other than those issued in connection with qualified home improvement and rehabilitation loans) made during the reporting period according to the annualized gross income of the borrowers (categorized in the following intervals of income: $0–$9,999; $10,000–$19,999; $20,000–$29,999; $30,000–$39,999; $40,000–$49,999; $50,000–$74,999; and $75,000 or more) and according to the acquisition cost of each residence being financed (categorized in the following intervals of acquisition cost: $0–$19,999; $20,000–$39,999; $40,000–$59,999; $60,000–$79,999; $80,000–$99,999; $100,000–$119,999; $120,000–$149,999; $150,000–$199,999; and $200,000 or more). For each interval of income and acquisition cost the table must also be categorized according to the number of borrowers that—

(*1*) Did not have a present ownership interest in a principal residence at any time during the 3-year period ending on the date the mortgage is executed (*i.e.*, satisfied the 3-year requirement) and purchased residences in targeted areas,

(*2*) Satisfied the 3-year requirement and purchased residences not located in targeted areas,

(*3*) Did have a present ownership interest in a principal residence at any time during the 3-year period ending on the date the mortgage is executed (*i.e.*, did not satisfy the 3-year requirement) and purchased residences in targeted areas, and

(*4*) Did not satisfy the 3-year requirement and purchased residences not located in targeted areas.

With respect to issues of qualified veterans' mortgage bonds, for each interval of income and acquisition cost the table need only be categorized according to the number of borrowers that satisfied the 3-year requirement and the number of borrowers that failed to satisfy the 3-year requirement.

(B) A table titled "Volume of Mortgage Loans by Income and Acquisition Cost" showing the total principal amount of the mortgage loans (other than qualified home improvement and rehabilitation loans) provided during the reporting period according to annualized gross income (categorized in the same intervals of income as the preceding table) and according to the acquisition cost of the residences acquired (categorized in the same acquisition cost intervals as the preceding table). For each interval of income and acquisition cost the table must also be categorized according to the total principal amount of the mortgage loans of borrowers that—

(*1*) Satisfied the 3-year requirement and purchased residences in targeted areas,

(*2*) Satisfied the 3-year requirement and purchased residences not located in targeted areas,

(*3*) Did not satisfy the 3-year requirement and purchased residences in targeted areas, and

(4) Did not satisfy the 3-year requirement and purchased residences not located in targeted areas.

With respect to issues of qualified verterans' mortgage bonds, for each interval of income and acquisition cost the table need only be categorized according to the total principal amount of the mortgage loans of borrowers that satisified the 3-year requirement and the total principal amount of the mortgage loans of borrowers that did not satisfy the 3-year requirement.

(C) For issues other than qualified veterans' mortgage bonds, a table titled "Mortgage Subsidy Bonds for Qualified Home Improvement and Rehabilitation Loans" showing the number of borrowers obtaining qualified home improvement loans and qualified rehabilitation loans and the total of the principal amounts of such loans; the information contained in the table must also be categorized according to whether the residences with respect to which the loans were provided are located in targeted areas.

(3) *Format.* (i) With respect to the report required by paragraph (k)(2)(ii) of this section, if no form is prescribed by the Internal Revenue Service, or if the prescribed form is not readily available, the issuer must submit the report in the format specified in this paragraph (k)(3).

(ii) With respect to issues of qualified mortgage bonds, the format of the report specified in this paragraph (k)(3) is the following:

**Qualified Mortgage Bond Information Report**

Name of issuer:
Address of issuer:
TIN of issuer:
Reporting period:

NUMBER OF MORTGAGE LOANS BY INCOME AND ACQUISITION COST

| 3-year requirement: Annualized gross monthly income of borrowers | Satisfied | | Not Satisfied | | Totals |
|---|---|---|---|---|---|
| | Nontargeted area | Targeted area | Nontargeted area | Targeted area | |
| $0 to $9,999 | | | | | |
| $10,000 to $19,999 | | | | | |
| $20,000 to $29,999 | | | | | |
| $30,000 to $39,999 | | | | | |
| $40,000 to $49,999 | | | | | |
| $50,000 to $74,999 | | | | | |
| $75,000 or more | | | | | |
| Total | | | | | |
| Acquisition Cost | | | | | |
| $0 to $19,999 | | | | | |
| $20,000 to $39,999 | | | | | |
| $40,000 to $59,999 | | | | | |
| $60,000 to $79,999 | | | | | |
| $80,000 to $99,999 | | | | | |
| $100,000 to $119,999 | | | | | |
| $120,000 to $149,999 | | | | | |
| $150,000 to $199,999 | | | | | |
| $200,000 or more | | | | | |
| Total | | | | | |

VOLUME OF MORTGAGE LOANS BY INCOME AND ACQUISITION COST

| 3-year requirement: Annualized gross monthly income of borrowers | Satisfied | | Not Satisfied | | Totals |
|---|---|---|---|---|---|
| | Nontargeted area | Targeted area | Nontargeted area | Targeted area | |
| $0 to $9,999 | | | | | |
| $10,000 to $19,999 | | | | | |
| $20,000 to $29,999 | | | | | |
| $30,000 to $39,999 | | | | | |
| $40,000 to $49,999 | | | | | |
| $50,000 to $74,999 | | | | | |
| $75,000 or more | | | | | |
| Total | | | | | |
| Acquisition Cost | | | | | |
| $0 to $19,999 | | | | | |
| $20,000 to $39,999 | | | | | |
| $40,000 to $59,999 | | | | | |
| $60,000 to $79,999 | | | | | |
| $80,000 to $99,999 | | | | | |
| $100,000 to $119,999 | | | | | |
| $120,000 to $149,999 | | | | | |
| $150,000 to $199,999 | | | | | |
| $200,000 or more | | | | | |
| Total | | | | | |

MORTGAGE SUBSIDY BONDS FOR QUALIFIED HOME IMPROVEMENT AND REHABILITATION LOANS

| | Nontargeted area | Targeted area | Totals |
|---|---|---|---|
| Number of qualified home improvement loans | | | |
| Volume of qualified home improvement loans | | | |
| Number of qualified rehabilitation loans | | | |
| Volume of qualified rehabilitation loans | | | |

(iii) The format of the report specified in this paragraph (k)(3) for qualified veterans' mortgage bonds is the following:

**Qualified Veterans' Mortgage Bond Information Report**

Name of issuer:
Address of issuer:
TIN of issuer:
Reporting period:

NUMBER OF MORTGAGE LOANS BY INCOME AND ACQUISITION COST

| 3-year requirement: annualized gross monthly income of borrowers | Satisfied | Not satisfied | Totals |
|---|---|---|---|
| $0 to $9,999 | | | |
| $10,000 to $19,999 | | | |
| $20,000 to $29,999 | | | |
| $30,000 to $39,999 | | | |
| $40,000 to $49,999 | | | |
| $50,000 to $74,999 | | | |
| $75,000 or more | | | |
| Total | | | |
| Acquistion Cost | | | |
| $0 to $19,999 | | | |
| $20,000 to $39,999 | | | |
| $40,000 to $59,999 | | | |
| $60,000 to $79,999 | | | |
| $80,000 to $99,999 | | | |
| $100,000 to $119,999 | | | |
| $120,000 to $149,999 | | | |
| $150,000 to $199,999 | | | |
| $200,000 or more | | | |
| Total | | | |

VOLUME OF MORTGAGE LOANS BY INCOME AND ACQUISITION COST

| 3-year requirement: annualized gross monthly income of borrowers | Satisfied | Not satisfied | Totals |
|---|---|---|---|
| $0 to $9,999 | | | |
| $10,000 to $19,999 | | | |
| $20,000 to $29,999 | | | |
| $30,000 to $39,999 | | | |
| $40,000 to $49,999 | | | |
| $50,000 to $74,999 | | | |
| $75,000 or more | | | |
| Total | | | |
| Acquistion Cost | | | |
| $0 to $19,999 | | | |
| $20,000 to $39,999 | | | |
| $40,000 to $59,999 | | | |
| $60,000 to $79,999 | | | |
| $80,000 to $99,999 | | | |
| $100,000 to $119,999 | | | |
| $120,000 to $149,999 | | | |
| $150,000 to $199,999 | | | |
| $200,000 or more | | | |
| Total | | | |

(4) *Definitions and special rules.* (i) For purposes of this paragraph the term "annualized gross income" means the borrower's gross monthly income multiplied by 12. Gross monthly income is the sum of monthly gross pay, any additional income from investments, pensions, Veterans Administration (VA) compensation, part-time employment, bonuses, dividends, interest, current overtime pay, net rental income, etc., and other income (such as alimony and child support, if the borrower has chosen to disclose such income). Information with respect to gross monthly income may be obtained from available loan documents, *e.g.*, the sum

of lines 23D and 23E on the Application for VA or FmHA Home Loan Guaranty or for HUD/FHA Insured Mortgage (VA Form 26–1802a, HUD 92900, Jan. 1982), or the total line from the Gross Monthly Income section of FHLMC Residential Loan Application form (FHLMC 65 Rev. 8/78). With respect to obligations issued prior to October 1, 1985, issuers may submit data based on annualized gross income or, instead, based on the adjusted income (as defined in § 1.167(k)–3(b)(3)) of the mortgagor's family for the previous calendar year. If data is submitted based on adjusted income, the issuer must note this fact in the report.

(ii) For purposes of this paragraph, the term "reporting period" means the following periods:

(A) The period beginning January 1, 1985, and ending on September 30, 1985,

(B) The period beginning on October 1, 1985, and ending on June 30, 1986, and

(C) After June 30, 1986, each 1-year period beginning July 1 and ending June 30.

(iii) See the regulations under section 103(l) for the definitions of the terms "date of issue", "maturity", and "term of issue".

(iv) For purposes of this paragraph, verification of information concernig a borrower's gross monthly income with other available information concerning the borrower's income (*e.g.*, Federal income tax returns) is not required. In determining whether a borrower acquiring a residence in a targeted area satisfies the 3-year requirement, the issuer may rely on a statement signed by the borrower.

(5) *Time for filing.* (i) The report required by paragraph (k)(2)(i) of this section shall be filed not later than the 15th day of the second calendar month after the close of the calendar quarter in which the obligation is issued. The statement may be filed at any time before such date but must be complete based on facts and reasonable expectations as of the date of issue. The statement need not be amended to report information learned subsequent to the date of issue or to reflect changed circumstances with respect to the issuer.

(ii) The report required by paragraph (k)(2)(ii) of this section (relating to use of proceeds) shall be filed not later than the 15th day of the second calendar month after the close of the reporting period, except that the report for the reporting period ending September 30, 1985, is due not later than February 15, 1986. The report may be filed at any time before such date but must be complete based on facts and reasonable expectations as of the date the report is filed. The report need not be amended to reflect information learned subsequent to the date the report is filed or to reflect changed circumstances with respect to any borrower.

(iii) The Commissioner may grant an extension of time for the filing of a report required by paragraph (k)(2) (i) or (ii) of this section if there is reasonable cause for the failure to file such report in a timely fashion.

(iv) An issue of qualified veterans' mortgage bonds issued after July 18, 1984, and prior to January 1, 1985, will be treated as satisfying the information reporting requirement of this paragraph if a Form 8038 with respect to the issue is properly filed not later than February 15, 1985; the report described in paragraph (k)(2)(ii) of this section need not be filed with respect to such issues.

(6) *Place for filing.* The reports required by paragraph (k)(2) (i) and (ii) of this section are to be filed at the Internal Revenue Service Center, Philadelphia, Pennsylvania 19255.

(l) *Policy statement*—(1) *In general.* (i) For obligations issued after December 31, 1984, an issue meets the requirements of this paragraph only if the applicable elected representative of the governmental unit which is the issuer (or on behalf of which the issuing authority is empowered to issue qualified mortgage bonds) has published (after a public hearing following reasonable public notice) the report described in paragraph (l)(3) of this section by the last day of the year preceding the year in which such issue is issued and a copy of such report has been submitted to the Commissioner on or before such last day. The Commissioner may grant an extension of time for publishing and filing the report if there is reasonable cause for the failure to publish or file such report in a timely fashion. The requirements of this paragraph will be treated as met if the issuer in good faith attempted to meet the policy statement requirements of this paragraph.

(ii) With respect to reports required by paragraph (l)(1)(i) of this section to be published and submitted to the Commissioner not later than December 31, 1984, the Commissioner has determined that there is reasonable cause for the failure to publish or file such reports in a timely fashion; such a report will be considered published and filed in a timely fashion if, not later than March 11, 1985, the report is published (after a public hearing following reasonable public notice) and a copy is submitted to the Commissioner. In addition, any report submitted not later than December 31, 1984, with respect to which an issuer in good faith attempted to satisfy the requirements of section 103A(j)(5) shall be treated as substantially satisfying the requirements of this paragraph. For example, with respect to a report submitted not later than December 31, 1984, an issuer shall not be treated as failing to satisfy the requirements of section 103A(j)(5) based on the fact that (A) the notice of public hearing failed to state the manner in which affected residents may obtain copies of the proposed report prior to the hearing, or (B) the proposed report was not available prior to or at the public hearing.

(2) *Definitions and special rules.* (i) In the case of an issuer that issues qualified mortgage bonds on behalf of one or more governmental units, a single report may be filed provided that such report is signed (A) by the applicable elected representative of each governmental unit on whose behalf obligations have been issued during any preceding calendar year or (B) by the Governor of the State in which the issuer is located.

(ii) See notice 103(k)(2)(E) and the regulations thereunder for the definition of the term "applicable elected representative".

(iii) In the case of qualified mortgage bonds issued by, or on behalf of, a governmental unit that did not reasonably expect during the preceding calendar year to issue (or have issued on its behalf by any other issuer) qualified mortgage bonds during the current calendar year, the requirements of this paragraph will be treated as met if the applicable governmental unit which is the issuer (or on behalf of which the issuing authority is empowered to issue qualified mortgage bonds) has published (after a public hearing following reasonable public notice) the report described in paragraph (l)(3) of this section prior to the issuance of any qualified mortgage bonds and a copy of such report has been submitted to the Commissioner prior to such issuance.

(iv) For purposes of this paragraph a report will be considered to be "published" when the applicable elected representative of the governmental unit has made copies of the report available for distribution to the public. Reasonable public notice of the manner in which copies of the report may be obtained must be provided; such notice may be included as part of the public notice required by paragraph (l)(4) of this section.

(3) *Report.* (i) A report is described in this paragraph (l)(3) if it contains the issuer's name, TIN, and the title "Policy Report Under Section 103A" stated on

the cover page of the report and if it includes—

(A) A statement of the policies of the issuer with respect to housing, development, and low-income housing assistance which such issuer is to follow in issuing qualified mortgage bonds and mortgage credit certificates, and

(B) An assessment of the compliance of such issuer during the 1-year period preceding the date of the report with—

(*1*) The statement of policy on qualified mortgage bonds and mortgage credit certificates that was set forth in the previous report, if any, of the issuer, and

(*2*) The intent of Congress that State and local governments are expected to use their authority to issue qualified mortgage bonds and mortgage credit certificates to the greatest extent feasible (taking into account prevailing interest rates and conditions in the housing market) to assist lower income families to afford home ownership before assisting higher income families.

(ii) For example, a report described in this paragraph (l)(3) may (but is not required to) contain—

(A) A specific statement of the policies with respect to housing, development, and low-income housing assistance which the issuer is to follow in issuing qualified mortgage bonds and mortgage credit certificates, including, for example, a statement as to—

(*1*) With respect to housing policies, (*i*) whether the proceeds will be used to provide financing for the acquisition of residences, to provide qualified home improvement loans, or to provide qualified rehabilitation loans; (*ii*) whether all or a portion of the proceeds will be targeted to new, existing, or any other particular class or type of housing; (*iii*) how the existence of a need or absence of a need for such targeting has been determined; (*iv*) the method by which the proceeds will be targeted; (*v*) any other pertinent information relating to the issuer's housing policies; and (*vi*) how the housing policies relate to the issuer's development and low-income housing assistance policies;

(*2*) With respect to development policies, (*i*) whether all or a portion of the proceeds will be targeted to specific areas (including targeted areas as described in § 6a.103A–2(b)(3)); (*ii*) a description of the areas to which the proceeds will be targeted; (*iii*) the reasons for selecting such areas; (*iv*) whether proceeds targeted to each area are to be used to finance redevelopment of existing housing or new construction; (*v*) any other pertinent information relating to the issuer's development policies; and (*vi*) how the development policies relate to the issuer's low-income housing assistance policies; and

(*3*) With respect to low-income housing assistance policies, (*i*) whether all or a portion of the proceeds will be targeted to low-income (*i.e.*, 80 percent of median income), moderate-income (*i.e.*, 100 percent of median income), or any other class of borrowers; (*ii*) the method by which the proceeds will be targeted to such borrowers; and (*iii*) any other pertinent information relating to the issuer's low-income housing assistance policies;

(B) An assessment of the compliance of the governmental unit or issuing authority during the twelve-month period ending with the date of the report with the statement of housing, development, and low-income housing assistance policies with respect to qualified mortgage bonds and mortgage credit certificates that were set forth in the report, if any, published in the preceding year with respect to such governmental unit, including, for example, a statement as to whether the governmental unit or issuing authority successfully implemented its policies and, if not, an analysis of the reasons for such failure; and

(C) An assessment of the compliance of the governmental unit or issuing authority during the twelve-month period ending with the date of the report with the intent of Congress that State and local governments are expected to use their authority to issue qualified mortgage bonds and mortgage credit certificates to the greatest extent feasible (taking into account prevailing interest rates and conditions in the housing market) to assist lower income families to afford home ownership before assisting higher income families, including, for example, a description of (*1*) the method used by the governmental unit or issuing authority to distribute proceeds, (*2*) whether and how that method enabled the governmental unit or issuing authority to assist lower income families before higher income families, and (*3*) any income levels that have been defined and used by the governmental unit or issuing authority in connection with distribution of the proceeds (no specific definition of lower income and higher income is imposed on governmental units or issuing authorities).

(*iii*) For purposes of the assessments of compliance required by paragraph (l)(3)(i)(B) of this section to be included in the report, the "date of the report" means June 30. For purposes of the report required to be filed prior to January 1, 1986, an issuer need not perform these assessments of compliance with respect to any period prior to January 1, 1985.

(iv) An issuer that fails to establish policies with respect to the criteria provided in paragraph (l)(3)(i) of this section will not be treated as failing to satisfy the requirements of this paragraph. Thus, for example, an issuer may state in its report that none of the proceeds of the issue will be targeted to specific areas. Similarly, an issuer that fails to successfully implement its policies will not be treated as failing to satisfy the requirements of this paragraph.

(4) *Public hearing.* The public hearing required by paragraph (l)(1) of this section means a forum providing a reasonable opportunity for interested individuals to express their views, both orally and in writing, on the report that the applicable representative proposes to publish to satisfy the requirements of this paragraph (l). A public hearing held prior to January 1, 1985, will not fail to satisfy the requirements of this paragraph (l)(4) merely because the proposed policy statement was not available prior to the public hearing. In general, a governmental unit may select its own procedure for the hearing, provided that interested individuals have a reasonable opportunity to express their views. Thus, it may impose reasonable requirements on persons who wish to participate in the hearing, such as a requirement that persons desiring to speak at the hearing so request in writing at least 24 hours before the hearing or that they limit their oral remarks to 10 minutes. For purposes of this public hearing requirement, it is not necessary that the applicable elected representative who will publish the report be present at the hearing, that a report on the hearing be submitted to that official, or that State administrative procedural requirements for public hearings in general be observed. However, compliance with such State procedural requirements (except those at variance with a specific requirement set forth in this paragraph) will generally assure that the hearing satisfies the requirements of this paragraph. The hearing may be conducted by any individual appointed or employed to perform such function by the governmental unit, its agencies, or by the issuer. Thus, for example, for a report to be issued by an issuing authority that acts on behalf of a county, the hearing may be conducted by the issuing authority, the county, or an appointee or employee of either.

(5) *Reasonable public notice.* (i) The reasonable public notice required by paragraph (l)(1) of this section means

published notice which is reasonably designed to inform residents of the geographical area within the jurisdiction of the governmental unit that will publish the report. The notice must state the time and place for the hearing and contain the information required by paragraph (l)(5)(ii) of this section. Notice is presumed reasonable if published no fewer than 14 days before the hearing. Notice is presumed reasonably designed to inform affected residents only if published in one or more newspapers of general circulation available to residents of that locality or if announced by radio or televison broadcast to those residents.

(ii) The notice of hearing described in this paragraph (l) (5) must state—

(A) The time and place for the hearing,

(B) Any applicable limitations regarding participation in the hearing,

(C) With respect to any notice of hearing published after December 31, 1984, the manner in which affected residents may obtain copies of the proposed report prior to the hearing, and

(D) With respect to any notice of hearing published after December 31, 1984, that the hearing will involve the issuer's policies with respect to housing, development, and low-income housing assistance which the issuer is to follow in issuing qualified mortgage bonds and mortgage credit certificates.

(6) *Procedure for public hearings of multiple jurisdiction issuers.* In the case of an issuer that issues qualified mortgage bonds on behalf of two or more governmental units ("multiple jurisdiction issuer"), each governmental unit on whose behalf the issuer reasonably expects to issue qualified mortgage bonds during the succeeding calendar year must hole a public hearing following reasonable public notice prior to the publication of the report required by this paragraph. A multiple jurisdiction issuer may hold a combined hearing as long as the combined hearing is a joint undertaking that provides all residents of the participating governmental units (*i.e.*, each governmental unit on whose behalf qualified mortgage bonds were issued by the authority and each governmental unit on whose behalf the authority reasonably expects to issue qualified mortgage bonds during the succeeding calendar year) a reasonable opportunity to be heard. The location of any combined hearing is presumed to provide a reasonable opportunity for all affected residents to be heard if it is no farther than 100 miles from the seat of government of each participating governmental unit beyond whose geographic jurisdiction the hearing is conducted.

(7) *Place for filing.* The report is to be filed with the Internal Revenue Service Center, Philadelphia, Pennsylvania 19255.

(m) *State certification requirements*—(1) *In general.* An issue meets the requirements of this paragraph only if the issuer in good faith attempted to meet the State certification requirements of this paragraph. The requirements of this paragraph apply to obligations issued after December 31, 1984.

(2) *Certification.* (i) An issue satisfied the requirements of section 103A (j) (4) and this paragraph (m)(2) only if the State official designated by law (or, if there is no State official, the Governor) certifies on or before the later of the date of issue or October 3, 1985, following a request for such certification by the issuer, that, as of the date the certification is executed, the issue meets the requirements of section 103A(g) and the regulations thereunder (relating to volume limitation). In the case of any constitutional home rule city, the certification shall be made by the chief executive officer of the city. To the extent consistent with State and local law, the Governor (or the chief executive officer of any constitutional home rule city) may delegate the responsibility to execute the certification required by this paragraph.

(ii) The certifying official need not perform an independent investigation in order to determine whether the issue meets the requirements of section 103A(g). In determining the aggregate amount of qualified mortgage bonds previously issued by an issuer during a calendar year, the certifying official may rely on copies of the reports submitted, to date, by the issuer pursuant to section 103A(j)(3) for other issues of qualified mortgage bonds issued during that year and copies of any elections previously made pursuant to section 25(c)(2) not to issue qualified mortgage bonds, together with an affidavit executed by an officer of the issuer responsible for issuing the bonds stating that the issuer has not, to date during the calendar year, issued any other qualified mortgage bonds, the amount, if any, of the issuer's market limitation that it has, to date during the calendar year, surrendered to other issuing authorities, and that it has not, to date during the calendar year, made any other elections not to issue qualified mortgage bonds. If, based on such information, the certifying official determines that, as of the date the certification is executed, the issue will not exceed the issuer's market limitation for the year, the official may certify that the issue meets the requirements of section 103A(g).

(3) *Special rule.* If 15 days elapse after the issuer files a proper request for the certification described in paragraph (m)(2) of this section and the issuer has not received from the State official designated by law (or, if there is no State official, the Governor) certification that the issue meets the requirements of section 103A(g) and § 6a.103A–2(g) or, in the alternative, a statement that the issue does not meet such requirements, the issuer may, instead, submit an affidavit executed by an officer of the issuer responsible for issuing the bonds stating that—

(i) The issue meets the requirements of section 103(A)(g) and § 6a.103A–2(g),

(ii) At least 15 days before the execution of the affidavit the issuer filed a proper request for the certification described in paragraph (m)(2) of this section, and

(iii) The State official designated by law (or, if there is no State official, the Governor) has not provided the certification described in paragraph (m)(2) of this section.

In the case of obligations issued prior to October 4, 1985 the preceding sentence shall be applied by substituting "30 days" for "15 days". For purposes of this paragraph, a request for certification is proper if the request includes the reports and affidavits described in paragraph (m)(2)(ii) of this section.

(4) *Filing.* The certification (or affidavit) required by this paragraph shall be filed with the Internal Revenue Service Center, Philadelphia, PA 19255. The certification (or affidavit) shall be submitted with the Form 8038 required to be filed by section 103A(j)(3) and paragraph (k) of this § 1.103A–2. The Commissioner may grant an extension of time for filing the certification (or affidavit) if there is a reasonable cause for the failure to file such statement in a timely fashion.

(5) *Effect of certification.* The fact that an issuer obtains the certification (or affidavit) described in this paragraph does not ensure that the requirements of paragraph (g) of § 6a.103A–2 are met. Obligations that do not meet the requirements of paragraph (g) of § 6a.103A–2 are not described in section 103 (a).

## PART 6a—TEMPORARY REGULATIONS UNDER TITLE II OF THE OMNIBUS RECONCILIATION ACT OF 1980

Par. 3. The authority for Part 6a continues to read in part:

Authority: 26 U.S.C. 7805. * * * sec. 6a.103A-2(k), (l), and (m) also issued under 26 U.S.C. 103A(j) (3), (4), and (5). * * *

Par. 4. Section 6a103A-2 is amended by revising paragraphs (k), (l), and (m). These revised provisions read as follows:

**§ 6a.103A-2 Qualified mortgage bond.**

* * * * *

(k) *Information reporting requirement.* See § 1.103A-2(k) for rules relating to section 103A(j)(3).

(l) *Policy statement.* See § 1.103A-2(l) for rules relating to section 103A(j)(5).

(m) *State certification.* See § 1.103A-2(m) for rules relating to section 103A(j)(4).

## PART 602—OMB CONTROL NUMBERS UNDER THE PAPERWORK REDUCTION ACT

Par. 5. The authority citation for Part 602 continues to read as follows:

Authority: 26 U.S.C. 7805.

Par. 6. Section 602.101(c) is amended by inserting in the appropriate places in the table "§ 1.103A-2 . . . . 1545-0720".

James I. Owens,

*Acting Commissioner of Internal Revenue.*

Approved: August 19, 1985.

Ronald A. Pearlman,

*Assistant Secretary of the Treasury.*

[FR Doc. 85-20978 Filed 8-29-85; 10:54 am]

BILLING CODE 4830-01-M

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**Fiscal Service**

**31 CFR Part 206**

## Management of Federal Agency Receipts and Operation of the Cash Management Improvements Fund

**AGENCY:** Financial Management Service, Fiscal Service, Treasury.

**ACTION:** Final rule.

**SUMMARY:** The Fiscal Service publishes this final rule to implement section 2652 of the Deficit Reduction Act of 1984, which gives the Secretary of the Treasury the authority to:

(1) Prescribe the methods by which an agency will collect and deposit monies to the Treasury;

(2) Prescribe the time within which an agency collecting monies must deposit such monies to Treasury;

(3) Assess charges for noncompliance in the amount determined to be the cost to the general fund of such noncompliance;

(4) Credit any charges imposed into the Cash Management Improvements Fund;

(5) Authorize use of any monies in the Fund for the payment of expenses incurred in developing and carrying out improved methods of collection and deposit.

This rule prescribes the policies and guidelines for promoting effective cash management through improved billing, collection, and deposit that result in improved availability of funds.

**EFFECTIVE DATE:** October 3, 1985.

**FOR FURTHER INFORMATION CONTACT:** Gerard M. McNiff, Program Initiatives Branch, Financial Management Service, Washington, DC (202/634-5783).

**SUPPLEMENTARY INFORMATION:** The Financial Management Service published a Notice of Proposed Rulemaking on pages 12333-12336 of the **Federal Register** of March 28, 1985. Public comment was invited for a 60-day period which ended May 28, 1985.

### Discussion of Public Comments

Twelve written comments were received, eleven from federal agencies and one from a trade association. The Financial Management Service ("Service") considered whether suggested changes to the proposed rule would (1) be consistent with the intent of Congress to ensure governmentwide cash management improvements, (2) ensure equitable treatment for all agencies, and/or (3) clarify Treasury requirements and agency responsibilities.

Discussion of the comments received are grouped below by section of the Notice of Proposed Rulemaking.

*1. Scope and Application*

Four commenters felt that clarification was required to explain whether all deposits were covered by the regulation. One commenter felt that voluntary donations received by an agency should be exempted from the scope of the regulation, while another felt that the text was inconsistent with the Supplementary Information, and should include donations within the scope. The Service has concluded that, from a cash management perspective, there is no logical reason to exclude donations from this regulation, and therefore rejects the suggestion to exempt donations.

One commenter felt the scope should include all deposits, specifically those received in foreign countries and international territories. The Service agrees and has clarified the rule accordingly. In addition, the scope encompasses fines and other civil penalties owed to the government.

One commenter felt that section 3720 is intended to encompass only monies placed in *Treasury's general fund,* as opposed to any monies deposited to a special, trust, or revolving fund, etc. This assumption is made because the legislation states that charges against an agency for failing to practice good cash management will be based on the cost of noncompliance to "the general fund." Furthermore, the commenter states, if section 3720 did apply, "a deposit into a revolving or trust fund that is not in compliance with Treasury's requirements would cause no loss of interest (actual or imputed) to the general fund and should not result in any penalty." This argument was rejected for several reasons. First, section 3720 states that an agency must provide for timely deposit of money *in accordance with section 3302.* Since section 3302 does not distinguish between deposits to distinct types of funds, no such distinction is applicable to section 3720. It is our opinion, which is supported by our legal counsel, that the Congressional intent was not to distinguish between deposits to the general fund as opposed to deposits to a trust fund, etc. Second, the argument that failure to comply with Treasury requirements will not cause a loss to the general fund is rejected. The intent of the legislation is to reduce the national deficit through improved governmentwide processing of collections and deposits. Therefore, failure to make a timely deposit into *any* fund will result in a cost to the government as a whole.

One comment was made about the portion of § 206.1 which stated that an agency is prohibited from entering into contractual agreements affecting collections without prior approval of Treasury. The commenter suggested the wording be clarified that Treasury has authority to approve collection systems, not terms of any acquisition or sales contract. The Service agrees with this suggestion, and has clarified the wording accordingly.

*2. Definitions*

There were three commenters who specifically addressed the "same day deposit" and "next day deposit" definitions. One commenter suggested changing the financial institution cutoff time in the example from 1 p.m. to 2 p.m. to be consistent with cutoff time guidelines found in Volume V, TFM Chapter 2020.19, while another commenter suggested deleting the words ". . . to be deposited . . ." from each definition. Both suggestions are accepted.

One commenter felt the next day definition should specify "next day for which both the agency and financial

institution are open for business". The Service assumes that both the same and next day definitions use the word "day" to mean a day that both the agency and the financial institution are open for business. Therefore, no change to the regulatory text is required. Another commenter felt that the current definitions imply that if an agency receives deposits after the financial institution cutoff time but deposits them the next business day, they would be considered "next day" deposits. The commenter felt that money received after the financial institution cutoff time should be counted as being received the following business day. The Service made next day deposit an acceptable timeframe to accommodate deposits received late in the day. Therefore, there is no need to change the language of the rule. One commenter felt the Treasury Financial Manual (TFM) definition should include reference to Part 5 of Volume 1 of the TFM. Although other volumes, parts and chapters of the TFM may contain cash management provisions, I TFM 6–8000 is the primary source of cash management guidance, and is the only necessary reference. This suggestion is therefore rejected.

*3. Billing Policy and Procedures*

One commenter questioned inclusion of specific billing timeframes within the regulation, feeling that this would allow Treasury to assess charges because of untimely billings, and therefore went beyond the "language of the law". This argument is rejected because the Service believes that the billing process is an integral part of collections, and therefore is covered under the legislation.

One agency commented that billing on a 5 day cycle would not be cost-effective given the type of collections involved for that particular agency, and therefore felt the requirement should be changed to a monthly billing cycle. A change to the basic requirement is rejected; the regulation already provides for billings later than the 5 day timeframe if an agency can demonstrate cost effectiveness.

Two commenters questioned when the 5 day billing timeframe begins. The text has been clarified on that point. In addition, an agency should be aware that the billing requirements apply to issuance of whatever initial notice is sent to impose a fine, charge, etc. Since an agency may spend weeks or months conducting an investigation to determine if a fine or charge should be imposed under its regulatory authority, the 5 day timeframe governs the period from: When an agency determines that, based on investigation, a fine should be imposed; to: Transmitting notification of the fine, etc., to the individual or organization being charged (transmitting of "the bill"). Determination of amounts to be charged can be considered part of the investigation phase.

Two commenters felt that the requirement for bills to include terms and dates of payment was inappropriate because terms are sometimes established by contract, etc. The regulatory requirement governs *inclusion* of payment terms on bills, but does not preclude an agency from negotiating such terms as appropriate.

*4. Collection Mechanisms*

Several commenters disagreed with language indicating that agency receipt of collections was "less desirable" than electronic funds transfer systems. The language has been clarified to more accurately reflect the Service's long term goal of moving toward improved electronic funds transfer (EFT) systems when cost-effective. The Service recognizes that an EFT system will not always be the most desirable way to process collections given characteristics of the cash flow and/or costs or limits of current EFT systems.

Several comments were received concerning the statements that "selection of the best collection mechanism is a joint responsibility of the agencies and the Service", and ". . . the Service is empowered to prescribe the use of a specific collection mechanism for mandatory use . . .". Some commenters perceived these as contradictory statements; in fact they are not. The Service, from a policy standpoint, ultimately intends to "institutionalize" cash management within each agency. In order to accomplish this, an agency must take an active role in discovering and recommending possible improvements. The Service therefore expects an agency to consider all internal factors in recommending an improvement; the Service will act as a "consultant" in this case. However, from a legal standpoint, the Service clearly has the authority to mandate use of a particular mechanism, and will exercise this authority if an agency refuses to voluntarily participate in the process of identifying areas for improvement. The language has therefore not been changed.

One commenter raised the same issue as discussed under the "Scope and Application" section related to the Service approval of contractual agreements. The language has been changed to clarify that the Service will not be approving terms of sale, but rather method of payment, i.e., collection system to be used.

One commenter felt that the NPRM implied an agency would be forced to bear excessive costs related to feasibility studies and implementation costs. The language has been modified to reflect joint Service-agency responsibility for costs as appropriate.

*5. Collection and Deposit Procedures*

Several commenters were confused about the intent of restricting mailing of deposits to Federal Reserve Banks. The language has been modified to make clear that mailing of deposits to *any* depositary should be done only when no other method of deposit is available. This section was not meant to discourage deposits to Federal Reserve Banks, as opposed to other financial institutions.

Several commenters were concerned about the ability to comply with the same day deposit requirement. One commenter felt the requirement was unreasonable because "receipt" is considered to be first receipt by an agency, not the "custodian" (i.e., individual responsible for actually making the deposit). Another commenter felt that there would be circumstances where an agency would be unable to meet the same day requirement during peak workload periods. Both of these suggestions are rejected for several reasons. If an agency is going to process collections, the Service expects the agency to meet the same processing times as could be achieved by lockbox processing. The Service recognizes in all requirements that there will be exceptions within an agency, because of unusual workload peaks, or for an agency as a whole, if it has unusual circumstances which make compliance impracticable. These instances are accommodated by the rule, but do not justify changing the rule.

Another agency felt that its deposit arrangements were an exception to the rule because its collections are turned over to a larger agency, which in turn actually makes the deposit and maintains accounting records. The commenter felt there would be a danger that it would be penalized for failure of the larger depositing agency to achieve same or next day deposit. Again, the Service is not convinced that the agency cannot take action to ensure compliance and clarify responsibility in any cases of noncompliance. An agency should understand that the fact that current procedures do not comply with this regulation does not mean that an agency should be exempted from a requirement, or the regulation changed. The requirements are not written to be easy to comply with; they are designed to

result in procedures to be followed when cost-effective to improve cash management. It is presumed that if current procedures do not meet these requirements, an agency will investigate and make all changes practical to ensure compliance. The Service will assist an agency on a consultant basis in suggesting cost effective alternatives to existing procedures.

*6. Cash Management Planning and Review*

Several commenters questioned the need for submission of an annual cash management plan. This requirement has been deleted from the final rule. An agency will be required to perform a cash management review to identify opportunities for improvement, and to report on these items. Subsequent annual reporting will only be required if there is a new cash flow or a substantial change to an existing cash flow.

Several commenters also suggested that agency reporting on initiative implementation and related savings should be unnecessary because collections are deposited with the Treasury. In the long term, Treasury's goal is to monitor cash management activities through Treasury information systems. At the present time, however, information is not available in a manner which makes this feasible.

*7. Charges*

Almost all commenters felt that there should be provisions to allow for agency appeal of charges. A formal appeal process had been drafted by the governmentwide task force. This provision was deleted by senior Service management prior to publication of the NPRM. The reason for deletion of the formal appeal process was a desire to avoid the traditional bureaucratic approach of excessive structure and formality. There is a basic assumption that Treasury management will exercise its authority in a responsible and reasonable manner, and that a formal appeal process is not a true substitute for the ability to recognize the larger picture and exercise good judgment. However, we also recognize the agency concern that there is an assurance of formal review of charges if necessary. Consequently, an appeal process has been included in the final rule. Commenter suggested numerous variations on composition of the appeals board. The task force also discussed a variety of options. The board will be composed of two Treasury officials and one agency official because legal counsel felt that the absence of a Treasury majority on the board would have resulted in an improper delegation of Treasury's legal authority to assess charges. Given the fact that the law does not require an appeal process, and that any charges will be assessed only after all other means of negotiation have failed, we feel that the appeal procedures should adequately address any remaining agency concerns. It should also be noted that although the cash managment review and identification of opportunities apply to both collections and payments, the authority to assess charges for noncompliance applies only to billings, collections, and deposits.

One commenter felt that Treasury should calculate the net cost to Treasury of noncompliance in instances where an agency earns interest from Treasury on agency deposits. Treasury will consider all applicable circumstances in calculating charges. However, as discussed under the scope and application section, the Service interprets the legislation to govern costs to the government as a whole, not necessarily net costs to the Treasury Department because of our present policy of giving an agency same day availability.

In any event, no change to the regulation is required, since an agency can appeal the calculation of the charge, if necessary.

Additional language has also been added to this section to clarify accounting procedures related to payment of charges.

*8. Operation of and Payments From the Cash Management Improvements Fund*

One commenter requested clarification of the possible use of monies in the fund. The language in the regulation is taken directly from the legislation, and applies only to collection and deposit systems, not payment systems. We interpret "personal services" to mean "personnel" services, which may include salaries or contracts.

Several commenters requested clarification of now to apply for payments from the Fund and who would authorize such payments. Clarifying language has been added to the final rule.

Section 206.9(a) provides that a charge will be levied on funds available for the "administration or operation" of programs to which the collections relate. The words "administration or operation" parallel language in various appropriations Acts; it is not the intent of the rule to charge funds available to an agency for substantive program expenditures.

**Special Analyses**

The Financial Management Service has determined that this final rule is not a major rule for purposes of E.O. 12291. Therefore, no regulatory impact analysis is required.

It has been certified that the rulemaking effected herein will not have a significant economic impact on a substantial number of small entities. Accordingly, a Regulatory Flexibility Act analysis is not required.

**List of Subjects in 31 CFR Part 206**

Banks, Banking.

**Carole Jones Dineen,**

*Fiscal Assistant Secretary.*

For the reasons set out in the preamble, a new Part 206 to 31 CFR Chapter II, is added to read as follows:

## PART 206—MANAGEMENT OF FEDERAL AGENCY RECEIPTS AND OPERATION OF THE CASH MANAGEMENT IMPROVEMENTS FUND

Sec.



**Authority:** 31 U.S.C. 321, 3301, 3302, and 3720.

### § 206.1 Scope and Application.

This regulation applies to all government departments and agencies in the Executive Branch (except Tennessee Valley Authority) and all monies collected by these departments and agencies. This regulation does not apply to interagency transfers. Policies and guidelines are prescribed for promoting effective cash management through improved billing, collection, and deposit that result in improved availability of funds. Authority to implement this regulation has been delegated within Treasury to the Commissioner of the Financial Management Service, hereinafter referred to as "the Service." The Service maintains the final authority as granted under the Deficit Reduction Act of 1984 to specify use of a particular method or mechanism of collection and deposit by an agency and to recover costs that result from noncompliance. An agency is prohibited under this regulation from entering into new contractual agreements or renewal of existing

contracts for agency collection systems without the prior approval of the Service, as described in the Treasury Financial Manual, Volume I, Chapter 6–8000 (I TFM 6–8000).

**§ 206.2 Definitions.**

For the purpose of this regulation, the following definitions apply:

(a) "Agency" means: Any department, instrumentality, office, commission, board, service, government corporation, or other establishment in the Executive Branch, except the Tennessee Valley Authority.

(b) "Billing" means: Any of a variety of means by which the Government places a demand for payment against an entity that is indebted to the Government. The term encompasses invoices, notices, initial demand letters, and other forms of notification.

(c) "Collect" means: The process of effecting a collection.

(d) "Collection" means: The transfer of monies from a source outside the Federal Government to an agency or to a financial institution acting as an agent of the Government.

(e) "Collection Mechanism" means: Any one of a number of tools or systems by which monies are transferred to the Government from a source outside the Government.

(f) "Cutoff time" means: A time predesignated by a financial institution beyond which transactions presented or actions requested will be considered the next banking day's business.

(g) "Deposit" means: As a noun, money that is being or has been presented for credit to the U.S. Treasury. Deposits can be made by an agency or directly by the remitter. All such transfers are effected through a Federal Reserve Bank or other financial institution. As a verb, the act of presenting monies for credit to the U.S. Treasury by an official of an agency.

(h) "Depositary" means: A bank or other financial institution which has been authorized by the U.S. Treasury to receive monies for credit to the U.S. Treasury.

(i) "Fund" means: The Cash Management Improvement Fund.

(j) "Monies" (or "receipts") means: Currency, negotiable instruments, and/or demand deposits owed to or collected by an agency.

(k) "Next Day Deposit" means: A deposit made before the cutoff time on the day following the day on which the funds were received by an agency. For example, if an agency receives funds for deposit at 3 pm on *Monday*, and transmits the deposits to the depositary by 2 pm on *Tuesday* (the depositary's next cutoff time) then next-day deposit requirements are met.

(l) "Same Day Deposit" means: A deposit made before the cutoff time on the day on which the funds were received by an agency. For example, if an agency receives funds for deposit at 10 am on *Monday* and transmits the deposits by 2 pm on *Monday* (the depositary's cutoff time) then same-day deposit has been achieved.

(m) "Service" means: The Financial Management Service (formerly the Bureau of Government Financial Operations), Department of the Treasury.

(n) "Treasury Financial Manual" (TFM) means: Manual issued by the Service containing procedures to be observed by all government departments and agencies in relation to central accounting, financial reporting, and other governmentwide fiscal responsibilities of the Department of the Treasury. Volume I, Chapter 6–8000 ("I TFM 6–8000") of the Manual contains cash management procedures to be followed pertaining to these regulations.

**§ 206.3 Billing Policy and Procedures.**

The billing process is considered an integral part of an effective cash management program. In those situations where bills are required and the failure to bill would affect the cash flow, bills will be prepared and transmitted within 5 business days after goods have been shipped or released, services have been rendered, or payment is otherwise due. An agency may prepare and transmit bills later than the 5 day timeframe if it can demonstrate that it is cost effective to do so. In addition, the bill must include the terms and dates of payments, and late payment provisions, if applicable. Terms and dates of payments will be consistent with industry practices. I TFM 6–8000 describes detailed billing policies, procedures, and industry standards.

**§ 206.4 Collection Mechanisms.**

(a) An agency's collection processes shall include procedures which provide for prompt and continuing action to collect monies owed to or received by that agency. I TFM 6–8000 prescribes guidelines to be followed in developing and implementing such procedures. Any such system must expedite credit and availability of these monies to the U.S. Treasury. Collections are made through a number of alternative collection mechanisms. The most fundamental form of collection mechanism requires the remitter to deliver monies to the offices of the agency responsible for the collection. Electronic funds transfer systems expedite credit and availability of funds into the banking system, thereby bypassing agency handling of monies. Treasury therefore endorses movement toward electronic funds transfer systems when they are determined to be cost-effective.

(b) In proposing an appropriate collection mechanism, an agency will attempt to minimize total costs to the Government, including known or estimated agency personnel costs, costs of procurement, equipment and system implementation and maintenance costs, and interest costs. A feasibility study, including a cost-benefit analysis, will normally be conducted by an agency and the Service prior to any decision on implementation of a certain mechanism. Improvements to the existing system will be addressed as one option. Interest savings should be measured against the existing deposit system. Future year cash flows will be considered especially if significant increases or decreases are projected. Seasonality (peak periods of collection) and the nature of the collection items (e.g., cash, check, money order) also must be considered. Interest savings will be addressed by source; e.g., elimination or reduction of mail, processing, and availability float.

(c) Selection of the best collection mechanism is a joint responsibility of an agency and the Service. An agency has the primary responsibility for conducting cash management reviews; documenting their collection systems; gathering volume and dollar data relative to the operation of the systems; taking the initiative to improve the mechanism for effecting their collections; and funding any implementation and operational costs above those normally funded by Treasury. The Service's primary role is as consultant, facilitator, and regulator and it will conduct periodic reviews of agencies; cash management programs in furtherance of that role. The Service is also the required approval authority when an agency desires to convert from one collection mechanism to another. The Service's approval must also be obtained prior to an agency entering into new contractual agreements or renewing existing contracts for agency collection systems.

(d) In view of the significant cash management savings that can accrue as a result of converting from one collection mechanism to another, the Service is empowered by the Deficit Reduction Act of 1984 to prescribe the use of a specific collection mechanism for mandatory use in a designated portion of an agency's collection system. In so doing, the Service shall give

consideration to all applicable factors, including but not limited to agency program requirements, an agency's costs of implementation, recurring operational costs, and other management improvements.

**§ 206.5 Collection and Deposit Procedures.**

(a) Prompt collection and deposit of monies are imperative to good cash management. This regulation prescribes the following timeframe requirements:

(1) An agency will achieve same day deposit of monies. Where same day deposit is not cost-effective or is impracticable, next day deposit of monies must be achieved.

(2) Deposits will be made at a time of the day prior to the depositary's specified cutoff time, but as late as possible in order to maximize daily deposit amounts.

(3) When cost-beneficial to the Government, an agency may make multiple deposits.

(b) Exceptions to the above policies are as follows:

(1) Collections of less than $1,000 may be accumulated and deposited when the total reaches $1,000. When an agency can fully cost-justify retaining collections in excess of $1,000, it may retain them. However, in no case will deposits be made less frequently than weekly.

(2) The mailing of deposits to depositaries (including Federal Reserve Banks or financial institutions) may be used, if approved by the Service, when all other methods of deposit cannot be cost-justified or no other method of deposit is available. In these cases, the deposit timeframe requirements apply to timely mailing of deposits.

(c) An agency will use expeditious procedures and processes in its receipt processing. Priority will be given to procedures which will expedite availability of funds to the Treasury. Automation will be used when it is cost beneficial to the Government. The current and future projection of volume of receipts will be given full consideration in all upgrades to systems.

**§ 206.6 Cash Management Planning and Review.**

(a) The primary responsibility to implement an effective cash management program rests with an agency. As part of its overall responsibility, an agency must constantly seek methods to bring about cash management savings and periodically perform cash management reviews to identify areas needing improvement.

(b) As part of its cash management review process, an agency is expected to document cash flows in order to provide an overview of its cash activities and to identify areas that will yield savings after cash management initiatives are implemented.

(c) An agency's initial and subsequent cash management reviews will provide the basis for identification of improvements and preparation of cash flow reports for submission to the Services as prescribed by I TFM 6–8000. That Chapter provides requirements for an agency in performing periodic cash managment reviews, identifying improvements, and preparing cash flow reports. The schedule for submission of information will be published in a TFM bulletin. In addition, periodic reports must be submitted by an agency to the Service on progress made in implementing cash management initiatives and associated savings.

(d) The Service will periodically review an agency's cash management program to ensure that adequate progress is being made to improve overall cash management at an agency. As part of its oversight authority, the Service may visit an agency and review all or specific cash management activities of an agency. An agency will be notified in advance of the Service's review and will be required to provide the Service with documentation of the agency cash management review within the timeframes and format required by I TFM 6–8000.

**§ 206.7 Notice of Deficiency.**

The Service will monitor agency cash management performance. Part of the monitoring process will include discussion and/or correspondence between the Service and an agency in which improved methods of cash management will be suggested and discussed. An agency will be given a full opportunity to concur or not concur and to recommend alternative solutions and implementation schedules. Following establishment of mechanism improvements and implementation end dates, an agency will be committed to completing these initiatives as scheduled. In cases where an agency fails to meet a scheduled implementation date within their control, the Commissioner, Financial Management Service, will send a formal Notice of Deficiency to an agency's designated cash management official. A separate notice will be sent for each initiative. The Notice of Deficiency will include at a minimum the nature of the deficiency, the amount of the proposed charge, the method of calculation, the right to file an appeal, and the date the charge will be imposed in the absence of an appeal.

**§ 206.8 Appeals.**

(a) An agency which chooses to file an appeal must submit the appeal in writing to the Commissioner, Financial Management Service, within 45 calendar days of the date of the Notice of Deficiency. In the event of an appeal, the charge imposed under the Notice of Deficiency will be deferred pending the results of the appeal. If an appeal is not submitted (i.e., received by the Commissioner, Financial Management Service) within 45 calendar days, the amount indicated in the Notice of Deficiency will be charged per § 206.9.

(b) The appeal shall contain the elements and follow the submission procedures specified in I TFM 6–8000. The appeal will include the background leading to the Notice of Deficiency, the basis of the appeal, and the action requested by an agency. An agency should state its disagreements with the Notice of Deficiency which may include cost/benefit factors, the amount of the charge, and other items.

(c) An agency must state what action it requests in its appeal. An agency may request that the Notice of Deficiency be completely overturned for cost/benefit or other considerations. Alternatively, an agency may request a reduced charge, deferral of the charge, an alternative solution to cash management improvement, or a combination of these actions.

(d) *Appeals Board.* The appeals board shall consist of three members—two permanent members and one temporary member. The permanent members will be the Commissioner, Financial Management Service, and the Assistant Commissioner, Federal Finance, Financial Management Service. The temporary board member will be a cash management official from a federal agency other than the agency appealing the Notice of Deficiency. The board will be convened on an as-needed basis; the order of agency assignment to the board will be published by Treasury. The Commissioner, Assistant Commissioner, and the designated agency cash management official may delegate their responsibility to a staff subordinate having sufficient experience in cash management matters. The Assistant Commissioner's designee may be from any area other than that which issued the Notice of Deficiency.

(e) *Appeal Review Process.* The appeals board will review the Notice of Deficiency, any additional information submitted by the Service, and the written appeal from an agency. Based

on this review, the board may decide additional investigation is required. The board may request an agency and/or the Service to meet with the board as part of the review process.

(f) *Appeal Finding.* A written majority decision shall be rendered by the appeals board within 30 calendar days of receipt of the appeal. The board may extend this period for an additional 30 calendar days if required. The decision of the board whether to uphold the Notice of Deficiency, to overturn the Notice of Deficiency, or to mandate some other action will be stated in the finding. Other action mandated may include a reduced charge, a deferral of the charge, an alternate solution to cash management improvement, or a combination of these actions. The basis of the decision, the amount of the charge and the effective date of the charge will be stated in the finding. The effective date of the charge may be retroactive to the date indicated in the Notice of Deficiency.

(g) Any terms related to charge deferral will be stated; the Service and an agency will be required to submit evidence of compliance to such terms at a future specified date. At this future time, the appeals board will review the evidence of compliance. Based on this evidence, the board will decide whether to impose a charge.

**§ 206.9 Charges.**

(a) Within 30 calendar days of the effective date of the charge or the appeals decision, an agency must submit appropriate accounting information to the Assistant Commissioner, Federal Finance, Financial Management Service. The charge will be calculated following procedures outlined in I TFM 6–8000, and will be assessed for each month that noncompliance continues. An agency will absorb the charge from within funds available for the administration or operation of the program(s) to which the collections relate.

(b) If an agency does not voluntarily pay the charge assessed under § 206.9(a), the Financial Management Service will debit the appropriate account automatically. By failing to voluntarily pay the charge as required by the Deficit Reduction Act of 1984, an agency shall be deemed to authorize the automatic debit to its account.

(c) The Commissioner, Financial Management Service will formally terminate the charge when the Commissioner has determined that an agency has complied. In addition, on an annual basis, the Commissioner will review an agency's performance and calculation of the charge, and will notify an agency in writing of any changes to the amount being charged.

**§ 206.10 Operation of and Payments from the Cash Management Improvements Fund.**

(a) The Cash Management Improvements Fund will be operated as a revolving fund by the Financial Management Service. Charges assessed under § 206.9 will be deposited into the Fund. The Financial Management Service will also disburse any payments from the Fund based on projects selected by a project selection and approval committee.

(b) *Committee Composition.* The committee shall consist of three members—two permanent members and one temporary member. The permanent members will be the Commissioner, Financial Management Service, and the Assistant Commissioner, Federal Finance, Financial Management Service. The temporary committee member will be a cash management official from a federal agency other than an agency being considered for funds. Decisions of the project selection and approval committee cannot be appealed. An agency will be notified of any available amounts in the Fund, and requirements to apply for such monies, through a TFM bulletin.

(c) As provided by 31 U.S.C. 3720, sums in the Fund shall be available without fiscal year limitation for the payment of expenses incurred in developing improved methods of collection and deposit and the expenses incurred in carrying out collections and deposits using such methods, including the costs of personal services and the costs of the lease or purchase of equipment and operating facilities.

(d) In addition to all reports required by law and regulation, the Treasury will prepare and publish a full report on receipts, disbursements, balances of the Fund, and full disclosure on projects financed by the Fund.

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## DEPARTMENT OF TRANSPORTATION

### Coast Guard

### 33 CFR Part 100

**[CGD3 85–53]**

## Special Local Regulations; Burlington Triathlon, Lake Champlain, Vermont

**AGENCY:** Coast Guard, DOT.

**ACTION:** Final rule.

**SUMMARY:** Special Local Regulations are being adopted for the swimming segment of the Burlington Triathlon. This event is sponsored by the Ski Rack Company of Burlington, VT. The event will be held on September 15, 1985 in Lake Champlain off North Beach just north of the City of Burlington, Vermont. This regulation is needed to provide for the safety of participants and spectators on navigable waters during this event.

**EFFECTIVE DATES:** This regulation becomes effective on September 15, 1985 from 8:30 a.m. to 11:00 a.m.

**FOR FURTHER INFORMATION CONTACT:** Mr. Lucas A. Dlhopolshy (212) 668–7974.

**SUPPLEMENTARY INFORMATION:** A Notice of Proposed Rule Making has not been published for these regulations and they are being made effective in less than 30 days from the date of publication. Following normal rulemaking procedures would have been impracticable. A determination was not made until 12 August 1985 that this marine event required a special local regulation and there was not sufficient time remaining to publish proposed rules in advance of the event or to provide for a delayed effective date.

**Drafting Information**

The drafters of this regulation are Mr. Lucas A. Dlhopolsky, Project Officer, Third Coast Guard District Boating Safety Division, and Ms. MaryAnn Arisman, Project Attorney, Thrid Coast Guard District Legal Office.

**Discussion of Regulations**

The Burlington Triathlon is a sporting contest, one segment of which involves a swimming event in Lake Chaplain. The contest is sponsored by the Ski Rack Company in Burlington, Vermont. The swimming portion of the triathlon will take place in Lake Champlain starting and finishing at the North Beach area located north of the City of Burlington between 8:30 a.m. and 11:00 a.m. on September 15, 1985. The swimming event is to be held on a triangular (isosceles) course whose apex is located in Lake Champlain, 1700 feet south of the North Beach bath house. Approximately 500 swimmers are expected to participate in this event. The sponsor is providing between four and six vessels, some with life guards aboard, in conjunction with Coast Guard and local authorities to patrol this event. Spectator craft will be required to remain 50 yards away from any point along the swimming course. In order to provide for the safety of life and property of both participants and spectators, the Coast Guard will restrict vessel movement in the regulated area.

**List of Subjects in 33 CFR Part 100**

Marine Safety, Navigation (water).

**Regulations**

In consideration of the foregoing, Part 100 of Title 33, Code of Federal Regulations, is amended as follows:

**PART 100—[AMENDED]**

1. The authority citation for Part 100 continues to read as follows:

**Authority:** 33 U.S.C. 1233; 49 CFR 1.46 and 33 CFR 100.35.

2. Part 100 is amended by adding a temporary § 100.35–320 to read as follows:

**§ 100.35–320 Burlington Triathlon, Burlington, Vermont**

(a) *Regulated Area:* Lake Champlain, off North Beach, located just north of Burlington, VT, within 50 yards of the swimming course which starts directly in front of the North Beach Bath House and extends south southeast 175 degrees True for a distance of 1700 feet to a point at Latitude 44 degrees 29 minutes 14 seconds North; Longitude 73 degrees 14 minutes 22 seconds West. Thence north northeast 035 degrees True returning to the beach.

(b) *Effective Period:* This regulation will be effective from 8:30 a.m. to 11:00 a.m. on September 15, 1985.

(c) *Special Local Regulations:* (1) The regulated area will be closed to all vessel traffic during the effective period. No person or vessel shall enter or remain in the regulated area when it is closed unless authorized by the sponsor or the Coast Guard Patrol Commander.

(2) All persons or vessels not registered with the sponsor as participants or not part of the marine event patrol are considered spectators. Spectator vessels must not enter the area within 50 yards of the swimming course.

(3) All persons and vessels shall comply with the instructions of U.S. Coast Guard patrol personnel. Upon hearing five or more blasts from a U.S. Coast Guard vessel, the operator of a vessel shall stop immediately and proceed as directed. U.S. Coast Guard patrol personnel include commissioned, warrant and petty officers of the Coast Guard. Members of the Coast Guard Auxiliary may be present to inform vessel operators of this regulation and other applicable laws.

(4) For any violation of this regulation, the following maximum penalties are authorized by law:

(i) $500 for any person in charge of the navigation of a vessel.

(ii) $500 for the owner of the vessel actually on board.

(iii) $250 for any other person.

(iv) Suspension or revocation of a license for a licensed officer.

Dated: August 23, 1985.

**P.A. Yost,**

*Vice Admiral, U.S. Coast Guard, Commander, Third Coast Guard District.*

[FR Doc. 85–20965 Filed 8–30–85; 8:45 am]

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**33 CFR Part 100**

**[CGD2 85–45]**

## Special Local Regulations; Fort Smith United Way Great Raft Race IX

**AGENCY:** Coast Guard, DOT.

**ACTION:** Final rule.

**SUMMARY:** Special local regulations are being adopted for Mile 308.5 to 301.0, Arkansas River. "Fort Smith United Way Great Raft Race IX", an approved marine event, will be held on September 14, 1985, at Fort Smith, Arkansas. These special local regulations are needed to provide for the safety of life and property on navigable waters during the event.

**EFFECTIVE DATES:** These regulations will be effective between the hours of 8:30 a.m. to 5:00 p.m. on September 14, 1985.

**FOR FURTHER INFORMATION CONTACT:** LCDR. B.J. Willis, Chief, Boating Technical Branch Second Coast Guard District, 1430 Olive St., St. Louis, MO 63103, Telephone: (314) 425–5971.

**SUPPLEMENTARY INFORMATION:** These special local regulations are issued pursuant to 33 U.S.C. 1233 and 33 CFR 100.35, for the purpose of promoting the safety of life and property on the Arkansas River between miles 308.5 and 301.0 during "FORT SMITH UNITED WAY GREAT RAFT RACE IX", September 14, 1985. This event will consist of non-powered, home made rafts, which could pose hazards to navigation in the area. Therefore, these special local regulations are deemed necessary for the promotion of safety of life and property in the area during this event. A notice of proposed rule making has not been published for these regulations and they are being made effective less than 60 days from the date of publication. Following normal rule making procedures would have been impracticable. The application for this event was not received until May 17, 1985, and there was insufficient time in which to publish proposed rules in advance of the event, or to provide for a delayed effective date. These regulations have been reviewed under the provisions of Executive Order 12291 and have been determined not to be a major rule. This conclusion follows from the fact that the duration of the regulated area is short. In addition, these regulations are considered to be nonsignificant in accordance with guidelines set forth in the Policies and Procedures for Simplification, Analysis, and Review of Regulations (DOT Order 2100.5 of 5–22–80). An economic evaluation has not been conducted since, for the reasons discussed above, its impact is expected to be minimal. In accordance with the Regulatory Flexibility Act (5 U.S.C. 601 et seq.), it is also certified that these rules will not have a significant economic impact on a substantial number of small entities. This rule is necessary to ensure the protection of life and property in the area during the event.

**Drafting Information**

The drafters of this regulation are BMCM W.L. Giessman, USCGR, project officer, Boating Technical Branch, and LT. R.E. Kilroy, USCG, project attorney, Second Coast Guard District Legal Office.

**List of Subjects in 33 CFR Part 100**

Marine Safety, Navigation (water).

**Regulations**

In consideration of the foregoing, Part 100 of Title 33, Code of Federal Regulations, is amended as follows:

**PART 100—[AMENDED]**

1. The authority citation for Part 100 continues to read as follows:

**Authority:** 33 U.S.C. 1233; 49 CFR 1.46 and 33 CFR 100.35.

2. In part 100, a new temporary § 100.35–0245 is added, to read as follows:

**§ 100.35–0245 Arkansas River, mile 308.5 through 301.0.**

(a) *Regulated Area:* The area between Mile 308.5 and 301.0 Arkansas River is designated the regatta area, and will be closed to commercial and recreational navigation or mooring between the hours of 8:30 a.m. and 5:00 p.m. on September 14, 1985. All times listed are local time.

(b) *Special Local Regulations:* The Coast Guard will maintain a patrol consisting of regular and auxiliary Coast Guard vessls in the regatta area. This patrol will be under the direction of a designated Coast Guard Patrol Commander. The Patrol Commander may be contacted on Channel 16 (156.8 MHZ) by the call sign "Coast Guard

Patrol Commander". Vessels desiring to transit the regulated area may do so only with prior approval of the Patrol Commander and when so directed by that officer. Vessels will be operated at a no wake speed to reduce the wake to a minimum and in a manner which will not endanger participants in the event or any other craft. The rules contained in the above two sentences shall not apply to participants in the event or vessels of the patrol operating in the performance of their assigned duties.

(c) The Patrol Commander may direct the anchoring, mooring or movement of any boat or vessel within the regatta area. A succession of sharp, short signals by whistle or horn from vessels patrolling the area under the direction of the U.S. Coast Guard Patrol Commander shall serve as a signal to stop. Vessels so signalled shall stop and shall comply with the orders of the Patrol Vessel. Failure to do so may result in expulsion from the area, citation for failure to comply, or both.

(d) The Patrol Commander may establish vessel size and speed limitations and operating conditions.

(e) The Patrol Commander may restrict vessel operation within the regatta area to vessels having particular operating characteristics.

(f) The Patrol Commander may terminate the marine event or the operation of any vessel at any time it is deemed necessary for the protection of life and property.

(g) This § 100.35–0245 will be effective from 8:30 a.m. on September 14, and terminate at 5:00 p.m. on September 14, 1985 (local time).

Dated: August 21, 1985.

**B.F. Hollingsworth,**

*Rear Admiral, U.S. Coast Guard Commander, Second Coast Guard District.*

[FR Doc. 85–20966 Filed 8–30–85; 8:45 am]

BILLING CODE 4910–14–M

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**33 CFR Part 100**

**[CGD2 85–46]**

## Special Local Regulations; Air Show and Boat Parade; Indiana

**AGENCY:** Indiana Coast Guard, DOT.

**ACTION:** Final rule.

**SUMMARY:** Special local regulations are being adopted for Mile 602.0 to 603.0, Ohio River. The "Air Show and Boat Parade", an approved marine event, will be held on September 7 and 8, 1985, at Jeffersonville, Indiana. These special local regulations are needed to provide for the safety of life and property on navigable waters during the event.

**EFFECTIVE DATES:** These regulations will be effective from 3:30 p.m. on September 7, and terminate at 5:00 p.m. on September 8, 1985.

**FOR FURTHER INFORMATION CONTACT:** LCDR. B. J. Willis, Chief, Boating Technical Branch Second Coast Guard District, 1430 Olive St., St. Louis, MO 63103, Telephone: (314) 425–5971.

**SUPPLEMENTARY INFORMATION:** These special local regulations are issued pursuant to 33 U.S.C. 1233 and 33 CFR 100.35, for the purpose of promoting the safety of life and property on the Ohio River between miles 602.0 and 603.0 during the "AIR SHOW AND BOAT PARADE", September 7 and 8, 1985. This event will consist of sky diving shows, aerobatic shows and a boat parade, which could pose hazards to navigation in the area. Therefore, these special local regulations are deemed necessary for the promotion of safety of life and property in the area during this event. A notice of proposed rule making has not been published for these regulations and they are being made effective less than 60 days from the date of publication. Following normal rule making procedures would have been impracticable. The application for this event was not received until May 14, 1985, and there was insufficient time in which to publish proposed rules in advance of the event, or to provide for a delayed effectie date. These regulations have been reviewed under the provisions of Executive Order 12291 and have been determined not to be a major rule. This conclusion follows from the fact that the duration of the regulated area is short. In addition, these regulations are considered to be nonsignificant in accordance with guidelines set forth in the Policies and Procedures for Simplification, Analysis, and Review of Regulations (DOT Order 2100.5 of 5–22–80). An economic evaluation has not been conducted since, for the reasons discussed above, its impact is expected to be minimal. In accordance with the Regulatory Flexibility Act (5 U.S.C. 601 et seq.), it is also certified that these rules will not have a significant economic impact on a substantial number of small entities. This rule is necessary to ensure the protection of life and property in the area during the event.

### Drafting Information

The drafters of this regulation are BMCM W. L. Giessman, USCGR, project officer, Boating Technical Branch, and LT. R. E. Kilroy, USCG, project attorney, Second Coast Guard District Legal Office.

### List of Subjects in 33 CFR Part 100

Marine Safety, Navigation (water).

### Regulations

In consideration of the foregoing, Part 100 of Title 33, Code of Federal Regulations, is amended as follows:

### PART 100—[AMENDED]

1. The authority citation for Part 100 continues to read as follows:

Authority: 33 U.S.C. 1233; 49 CFR 1.46 and 33 CFR 100.35.

2. In part 100, a new temporary § 100.35–0246 is added, to read as follows:

**§ 100.35–0246, Ohio River, mile 602.0 through 603.0.**

(a) *Regulated Area:* The area between Mile 602.0 and 603.0 Ohio River is designated the regatta area, and may be closed to commercial and recreational navigation or mooring between the hours of 3:30 p.m. on September 7, and 5:00 p.m. on September 8, 1985. All times listed are local time. These times represent a guideline for possible intermittent river closures not to exceed THREE (3) hours in duration. Mariners will be afforded enough time between such closure periods to transit the area in a timely manner.

(b) *Special Local Regulations:* The Coast Guard will maintain a patrol consisting of regular and auxiliary Coast Guard vessels in the regatta area. This patrol will be under the direction of a designated Coast Guard Patrol Commander. The Patrol Commander may be contacted on Channel 16 (156.8 MHZ) by the call sign "Coast Guard Patrol Commander". Vessels desiring to transit the regulated area may do so only with prior approval of the Patrol Commander and when so directed by that officer. Vessels will be operated at a no wake speed to reduce the wake to a minimum and in a manner which will not endanger participants in the event or any other craft. The rules contained in the above two sentences shall not apply to participants in the event or vessels of the patrol operating in the performance of their assigned duties.

(c) The Patrol Commander may direct the anchoring, mooring or movement of any boat or vessel within the regatta area. A succession of sharp, short signals by whistle or horn from vessels patrolling the area under the direction of the U.S. Coast Guard Patrol Commander shall serve as a signal to stop. Vessels so signalled shall stop and shall comply with the orders of the Patrol Vessel. Failure to do so may result in expulsion

from the area, citation for failure to comply, or both.

(d) The Patrol Commander may establish vessel size and speed limitations and operating conditions.

(e) The Patrol Commander may restrict vessel operation within the regatta area to vessels haivng particular operating characteristics.

(f) The Patrol Commander may terminate the marine event or the operation of any vessel at any time it is deemed necessary for the protection of life and property.

(g) This § 100.35–0246 will be effective from 3:30 p.m. on September 7, and terminate at 5:00 p.m. on September 8, 1985. (local time).

Dated: August 21, 1985.

**B.F. Hollingsworth,**

*Rear Admiral, U.S. Coast Guard Commander, Second Coast Guard District.*

[FR Doc. 85–20967 Filed 8–30–85; 8:45 am]

BILLING CODE 4910–14–M

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**33 CFR Part 165**

**[COTP LA/LB–85–08]**

## Safety Zone, Santa Cruz Island

**AGENCY:** Coast Guard, DOT.

**ACTION:** Final rule.

**SUMMARY:** A safety zone is being established in the territorial waters south of Santa Cruz Island. Tests of submerged and semisubmerged vessels will be conducted during a three month period. There will also be placement of fixed underwater sound systems making transit, anchoring or fishing hazardous. Limiting access to this area will serve to protect vessels and sensitive underwater gear. This regulation is exempt from certain provisions of 5 U.S.C. 553 because it involves a foreign or military affairs function of the United States.

**EFFECTIVE DATE:** September 3, 1985.

**FOR FURTHER INFORMATION CONTACT:** Lieutenant Commander Jeff Parks, U.S. Coast Guard, U.S. Coast Guard Operations Division, Eleventh Coast Guard District, Long Beach, California.

### Supplementary Information

On 1 August 1985 the Coast Guard published a notice of proposed rule making in the **Federal Register** for these regulations (50 FR 31198). Interested persons were requested to submit comments and 3 comments were received.

### Drafting Information

The drafters of these regulations are Lieutenant Commander Jeff Parks, Project Officer, Eleventh Coast Guard District Operations Division, project officer and Lieutenant Joseph R. McFaul, Project Attorney, Eleventh Coast Guard District Legal Office.

### Discussion of Comments

On 31 July 1985 a meeting was held at the Pacific Missile Test Center, Point Mugu California, between U.S. Navy Representatives and representatives of commercial user groups. Several fishermen stated that they would be losing money if denied access to shallow waters to set crab and lobster traps. Several users also stated that waters South of Santa Cruz Island serve as a natural lee during rough weather. Navy representatives promised to notify the Coast Guard when waters enclosed by the safety zone can be safely used by mariners and fishermen.

Additionally, the three written commenters expressed concern that the regulations would prevent access to fishing areas during the peak fishing season. One commenter suggested that permission to enter the zone be granted whenever testing would not be hazardous. This suggestion will be adopted. A hot-line will be established so that adverse effects on potential users will be minimized. Callers will be able to call the hot-line to determine if the zone can be entered. Adjustments to the zone may be made, as testing permits, to accommodate fishing seasons. These will be published in the Local Notice to Mariners and announced on the hot-line. The zone remains in effect at all times from September 3, 1985 to November 30, 1985, unless permission to enter the zone is granted by means of the hot-line or the Local Notice to Mariners.

### List of Subjects in 33 CFR Part 165

Harbors, Marine safety, Navigation (water), Security measures, Vessels, Waterways.

### PART 165—[AMENDED]

### Final Regulations

In consideration of the foregoing, Part 165 of Title 33, Code of Federal Regulations, is amended as follows:

1. The authority citation for Part 165 continues to read as follows:

**Authority:** 33 U.S.C. 1225 and 1231; 50 U.S.C. 191; 49 CFR 1.46 and 33 CFR 1.05–1(g), 6.04–1, 604–6, and 160.5.

2. Section 165.T1176 is added to read as follows:

**§ 165.T1176 Santa Cruz Island.**

(a) A safety zone is established to include all waters enclosed within lines drawn from the following points: Beginning from a point on land located approximately at Latitude 33–57.9 N, Longitude 119–42.6 W, then due south to a point on the territorial sea located approximately at Latitude 33–54.9 N, Longitude 119–42.6 W, then following the limit of the territorial sea in an easterly direction to a point approximately located at Latitude 33–56.8 N, Longitude 119–34.5 W, then due north to a point on land located approximately at Latitude 33–59.8 N, Longitude 119–34.5 W, then returning along the shore to the beginning point.

(b) No person may swim, skin dive or scuba dive in the waters within the safety zone.

(c) No vessel may navigate, transit, fish, anchor or drift in the waters within the safety zone.

(d) Any vessel within the zone shall follow the directions of the patrolling Coast Guard cutter.

(e) This regulation is effective on September 3, 1985 and remains continuously in force until November 30, 1985.

Dated: August 26, 1985.

**A.B. Beran,**

*Commodore, U.S. Coast Guard, Commander, Eleventh Coast Guard District.*

[FR Doc. 85–20968 Filed 8–30–85; 8:45 am]

BILLING CODE 4910–14–M

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## DEPARTMENT OF DEFENSE

## Corps of Engineers, Department of the Army

**36 CFR Part 327**

## Public Use of Water Resource Development Projects Administered by the Chief of Engineers

**AGENCY:** U.S. Army Corps of Engineers, DOD.

**ACTION:** Final rule.

**SUMMARY:** This final rulemaking supersedes the regulation dated May 1979. The regulation is designed to ensure safe, enjoyable and environmentally sound visitation on the public lands, free from unwarranted disturbances. This is accomplished by setting minimum standards of conduct for persons using the public lands and establishing penalties that may be imposed for failure to obey the regulation.

These rules and regulations apply to water resource development projects, completed or under construction, administered by the Chief of Engineers, and to those portions of jointly administered water resource projects

which are under the administrative jurisdiction of the Chief of Engineers, including the Central and Southern Florida flood control project as authorized by the Flood Control Act of 1968.

**EFFECTIVE DATE:** January 1, 1986.

**FOR FURTHER INFORMATION CONTACT:** Darrell E. Lewis, Chief, Natural Resources Management Branch, U.S. Army Corps of Engineers, HQUSACE, ATTN: DAEN–CWO–R, Washington, D.C. 20314–1000.

**SUPPLEMENTARY INFORMATION:**

### Amendments

The amendments to Part 327 are necessary to clarify and strengthen selected regulations for more effective management and to enhance public enjoyment of Corps water resource development projects. Some of the sections have been reworded and/or relocated to a different section. These minor changes are editorial in nature and have been made to express the intent of the regulation more concisely. They are not listed individually.

Section 327.1 concerning the statement of policy has been enlarged to contain former § 327.23 Outgranted Lands and § 327.24 Indian Lands. Paragraph (g) is added to this section instead of being listed in individual sections throughout the regulation. Paragraph (h) has been expanded to include the use of vessels and aircraft, in addition to vehicles.

Section 327.2 concerning vehicles has been expanded to address the removal of illegally parked vehicles and to allow exhaust muffler noise limits to be determined as defined by state and local laws.

Section 327.3 concerning vessels has been expanded to better define vessels and allow for means of identification of vessels by requiring the display of appropriate U.S. Coast Guard or state registration whenever they are operated on project waters. Safety equipment should conform to state safety laws in addition to U.S. Coast Guard requirements. Exhaust muffler noise limits may be determined by state and local laws.

Section 327.4 concerning aircraft has been restructured in order to better define aircraft.

Section 327.5 concerning swimming has been expanded to require that an international diving flag be displayed during underwater activities.

Section 327.8 concerning hunting, fishing, and trapping has been expanded to indicate that all Federal, state, and local laws governing these activities are applicable on project lands.

Section 327.9 concerning sanitation has been expanded to include all references to sanitation previously contained in other sections.

Section 327.10 concerning fires has been expanded to require fuels be stored in containers designed for such purposes and has restricted the throwing or dropping of lighted smoking materials.

Section 327.11 concerning the control of animals has been expanded to prohibit a person from allowing animals to impede or restrict the otherwise full and free use by the public of the project lands.

Section 327.12 concerning restrictions has been expanded to include disruptive behavior and to define noise production devices and excessive noise levels.

Section 327.15 concerning the abandonment of personal property has been expanded to assist in the control of encroachments.

Section 327.24 concerning interference with Government employees has been revised to incorporate the provisions of Sections 1114 and 111 of Title 18 USC for certain Corps of Engineers employees, as allowed by Pub. L. 98–63.

Section 327.26 concerning state and local laws has been added to properly address the role of state and local law enforcement agencies on lands managed by the Corps of Engineers.

The U.S. Army Corps of Engineers has determined that this document is not a major rule under Executive Order 12291. It has been determined under the criteria of the Regulatory Flexibility Act that this final rule will not have a significant impact on a substantial number of small entities.

### List of Subjects in 36 CFR Part 327

Penalties, Recreation and recreation areas, Water resources.

Accordingly, 36 CFR Part 327 is revised to read as follows:

## PART 327—RULES AND REGULATIONS GOVERNING PUBLIC USE OF WATER RESOURCE DEVELOPMENT PROJECTS ADMINISTERED BY THE CHIEF OF ENGINEERS

Sec.



**Authority:** Sec. 4, Act of December 22, 1944, 58 Stat. 889, as amended (16 U.S.C. 460d); sec. 210 of Pub. L. 90–483, 82 Stat. 746; and Pub. L. 88–578, 78 Stat. 897, as amended (16 U.S.C. 460l–6a)

### § 327.0 Applicability.

The regulations covered in this Part 327 shall be applicable to water resource development projects, completed or under construction, administered by the Chief of Engineers, and to those portions of jointly administered water resource development projects which are under the administrative jurisdiction of the Chief of Engineers. All other Federal, State and local laws and regulations remain in full force and effect where applicable to those water resource development projects.

### § 327.1 Policy.

(a) It is the policy of the Secretary of the Army, acting through the Chief of Engineers, to manage the natural, cultural and developed resources of each project in the public interest, providing the public with safe and healthful recreational opportunities while protecting and enhancing these resources.

(b) Unless otherwise indicated herein, the term "District Engineer" shall include the authorized representatives of the District Engineer.

(c) The term "project" or "water resource development project" refers to the water areas of any water resource development project administered by the Chief of Engineers, without regard to ownership of underlying land, to all lands owned in fee by the Federal Government and to all facilities therein or thereon of any such water resource development project.

(d) All water resource development projects open for public use shall be available to the public without regard to sex, race, color, creed, age, nationality or place of origin. No lessee, licensee, or

concessionaire providing a service to the public shall discriminate against any person because of sex, race, creed, color, age, nationality or place of origin in the conduct of the operations under the lease, license or concession contract.

(e) In addition to the regulations in this Part 327, all applicable Federal, state and local laws and regulations remain in full force and effect on project lands or waters which are outgranted by the District Engineer by lease, license or other written agreement.

(f) The regulations in this Part 327 shall be deemed to apply to those lands and waters which are subject to treaties and Federal laws and regulations concerning the rights of Indian Nations and which lands and waters are incorporated, in whole or in part, within water resource development projects administered by the Chief of Engineers, to the extent that the regulations in this Part 327 are not inconsistent with such treaties and Federal laws and regulations.

(g) Any violation of any section of this Part 327 shall constitute a separate violation for each calendar day in which it occurs.

(h) For the purposes of this Part 327, the owner of any unattended vehicle, vessel or aircraft as described herein shall be presumed to be responsible for its use on project property. Unless proven otherwise, such presumption will be sufficient to issue a citation for the violation of regulations applicable to the use of such vehicle, vessel or aircraft as provided for in § 327.25, Violation of Rules and Regulations.

**§ 327.2 Vehicles.**

(a) This section pertains to all vehicles, including, but not limited to, automobiles, trucks, motorcycles, mini-bikes, snowmobiles, dune buggies, all-terrain vehicles and trailers, campers, bicycles or any other such equipment.

(b) Vehicles shall not be parked in violation of posted restrictions, or in such a manner as to obstruct or impede normal or emergency traffic movement or the parking of other vehicles, create a safety hazard, or endanger any person, project property or environmental feature. Vehicles so parked are subject to removal and impoundment at the owner's expense.

(c) The operation and/or parking of a vehicle off authorized roadways is prohibited except at locations and times designated by the District Engineer. Taking any vehicle through, around or beyond a restrictive sign, recognizable barricade, fence or traffic control barrier is prohibited.

(d) Vehicles shall be operated only in accorance with posted regulations and applicable Federal, state and local laws, which shall be enforced by authorized enforcement officials.

(e) No person shall operate any vehicle in a careless, negligent or reckless manner so as to endanger any person, project property or environmental feature.

(f) At developed recreation areas, vehicles shall be used only to enter or leave the area or individual sites or facilities unless otherwise posted.

(g) Except as authorized by the District Engineer, no person shall operate any motorized vehicle without a proper and effective exhaust muffler as defined by state and local laws, or with an exhaust muffler cutout open, or in any other manner which renders the exhaust muffler ineffective in muffling the sound of engine exhaust.

**§ 327.3 Vessels.**

(a) This section pertains to all vessels or watercraft, including, but not limited to, powerboats, cruisers, houseboats, sailboats, rowboats, canoes, kayaks, jetskis and any other such equipment capable of navigation on water, whether in motion or at rest.

(b) The placement and/or operation of any vessel or watercraft for a fee or profit upon project waters or lands is prohibited except as authorized by permit, lease, license, or concession contract with the Department of the Army. This paragraph (§ 327.3(b)) shall not apply to the operation of commercial tows or passenger carrying vessels not based at a Corps project which utilize project waters as a link in continous transit over navigable waters of the United States.

(c) Vessels or other watercraft may be operated on the project waters, except in prohibited or restricted areas, in accordance with posted regulations, including buoys, and applicable Federal, state and local laws, as regulated by authorized enforcement officials. All vessels or watercraft so required by applicable Federal, state and local laws shall display an appropriate registration on board whenever the vessel is operated on project waters.

(d) The operation of vessels or other watercraft in a careless, negligent or reckless manner so as to endanger any property or person (including the operator and/or user(s) of the vessel or watercraft) is prohibited.

(e) All vessels, when in use, shall have safety equipment, including personal floatation devices, on board in compliance with U.S. Coast Guard boating safety requirements (Coast Guard Pamphlet CG–290; 46 CFR Parts 25, 30; 33 CFR Part 175) and in compliance with boating safety laws issued and enforced by the state in which the vessel is being operated.

(f) Unless otherwise permitted by Federal, state or local law, vessels or other watercraft, while moored in commercial facilities, community or corporate docks, or at any fixed or permanent mooring point, may only be used for overnight occupancy when such use is incidental to recreational boating. Vessels or other watercraft are *not* to be used as a place of habitation or residence.

(g) Water skis, parasails, ski-kites and similar devices are permitted in nonrestricted areas except that they may not be used in a careless, negligent, or reckless manner so as to endanger any property or person (including the user and/or operator of the towing vessel).

(h) All vessels when not in actual use shall be removed from project lands and water unless securely moored or stored at designated areas approved by the District Engineer. The placing of floating or stationary mooring facilities on, adjacent to, or interfering with a buoy, channel marker or other navigational aid is prohibited.

(i) The use at a project of any vessel not constructed or maintained in compliance with the standards and requirements established by the Federal Safe Boating Act of 1971 (Pub. L 92–75, 85 Stat. 213), or promulgated pursuant to such act, is prohibited.

(j) Except as authorized by the District Engineer, no person shall operate any vessel or watercraft without a proper and effective exhaust muffler as defined by State and local laws, or with an exhaust muffler cutout open, or in any other manner which renders the exhaust muffler ineffective in muffling the sound of engine exhaust.

**§ 327.4 Aircraft.**

(a) This section pertains to all aircraft including, but not limited to, airplanes, seaplanes, helicopters, ultralight aircraft, motorized hang gliders, hot air balloons, any non-powered flight devices or any other such equipment.

(b) The operation of aircraft on project lands at locations other than those designated by the District Engineer is prohibited. This provision shall not be applicable to aircraft engaged on official business of Federal, state or local governments or law enforcement agencies, aircraft used in emergency rescue in accordance with the directions of the District Engineer or aircraft forced to land due to circumstances beyond the control of the operator.

(c) No person shall operate any aircraft while on or above project

waters or project lands in a careless, negligent or reckless manner so as to endanger any person or property.

(d) Nothing in this section (§ 327.4) bestows authority to deviate from rules and regulations or prescribed standards of the appropriate State Aeronautical Agency, or the Federal Aviation Administration, including, but not limited to, regulations and standards concerning pilot certifications or ratings, and airspace requirements.

(e) Except in extreme emergencies threatening human life or serious property loss, the air delivery of any person, material or equipment by parachute, helicopter or other means onto project lands or waters without written permission of the District Engineer is prohibited.

(f) In addition to the above provisions, seaplanes, as defined below, are subject to the following restrictions:

(1) Such use is limited to aircraft utilized for water landings and takeoff, herein called seaplanes, at the risk of the owner, operator and passenger(s).

(2) Seaplane operations contrary to the prohibitions or restrictions established by the District Engineer (pursuant to Part 328 of Title 36) are prohibited. The responsibility to ascertain whether seaplane operations are prohibited or restricted is incumbent upon the person(s) contemplating the use of, or using, such waters.

(3) All operations of seaplanes while upon project waters shall be in accordance with marine rules of the road for power boats or vessels and § 327.3 Vessels.

(4) Seaplanes on project waters and lands in excess of 24 hours shall be securely moored at mooring facilities and at locations permitted by the District Engineer. Seaplanes may be temporarily moored on project waters and lands, except in areas prohibited by the District Engineer, for periods less than 24 hours providing that (i) the mooring is safe, secure, and accomplished so as not to damage the rights of the Government or members of the public and (ii) the operator remains in the vicinity of the seaplane and reasonably available to relocate the seaplane if necessary.

(5) Commercial operation of seaplanes from project waters is prohibited without written approval of the District Engineer following consultation with and necessary clearance from the Federal Aviation Administration (FAA) and other appropriate public authorities and affected interests.

(6) Seaplanes may not be operated at Corps projects between sunset and sunrise unless adequate lighting and supervision approved by the District Engineer are available.

### § 327.5 Swimming.

(a) Swimming, diving, snorkling or scuba diving at one's own risk is permitted, except at launching sites, designated mooring points and other areas so designated by the District Engineer. Diving or jumping from bridges or other structures which cross project waters is prohibited.

(b) An international diving flag must be displayed during underwater activities.

### § 327.6 Picnicking.

Picnicking and related day-use activities are permitted, except in those areas where prohibited by the District Engineer.

### § 327.7 Camping.

(a) Camping is permitted only at sites and/or areas designated by the District Engineer.

(b) Camping at one or more campsites at any one water resource project for a period longer than 14 days during any 30-consecutive-day period is prohibited without the written permission of the District Engineer.

(c) The unauthorized placement of camping equipment or other items on a campsite and/or personal appearance without overnight occupancy at a campsite for the purpose of reserving a designated campsite for future occupancy is prohibited.

(d) The digging or leveling of any ground or the construction of any structure without written permission of the District Engineer is prohibited.

### § 327.8 Hunting, fishing, and trapping.

Hunting, fishing, and trapping are permitted except in areas where prohibited by the District Engineer. All Federal, state and local laws governing these activities apply on project lands and waters, as regulated by authorized enforcement officials.

### § 327.9 Sanitation.

(a) Garbage, trash, rubbish, litter, or any other waste material or waste liquid generated on the project and incidental to authorized recreational activities shall be either removed from the project or deposited in receptacles provided for that purpose. The improper disposal of such wastes, human and animal waste included, on the project is prohibited.

(b) It is a violation to bring onto a project any household or commercial garbage, trash, rubbish, debris, dead animals or litter of any kind for disposal or dumping without the written permission of the District Engineer.

(c) The spilling, pumping or other discharge of contaminants, pollutants or other wastes, including, but not limited to, human or animal waste, petroleum, industrial and commercial products and by-products, on project lands or into project waters is prohibited.

(d) Campers, picnickers, and all other persons using a water resource development project shall keep their sites free of trash and litter during the period of occupancy and shall remove all personal equipment and clean their sites upon departure.

(e) The discharge or placing of sewage, galley waste, garbage, refuse, or pollutants into the project waters from any vessel or watercraft is prohibited.

### § 327.10 Fires.

(a) Gasoline and other fuels, except that which is contained in storage tanks of vehicles, vessels, camping equipment, or hand portable containers designed for such purpose, shall not be carried onto or stored on the project without written permission of the District Engineer.

(b) Fires shall be confined to those areas designated by the District Engineer, and shall be contained in fireplaces, grills, or other facilities designated for this purpose. Fires shall not be left unattended and must be completely extinguished prior to departure. The burning of materials that produce toxic fumes, including, but not limited to, tires, plastic or treated wood products is prohibited.

(c) Improper disposal of lighted smoking materials, matches or other burning material is prohibited.

### § 327.11 Control of animals.

(a) No person shall bring or allow dogs, cats, or other pets into developed recreation areas unless penned, caged, on a leash under 6 feet in length, or otherwise physically restrained. No person shall allow animals to impede or restrict otherwise full and free use of project lands and waters by the public. All animals and pets are prohibited in swimming beaches. Animals and pets, except properly trained animals assisting the handicapped (such as seeing-eye dogs), are prohibited in sanitary facilities or other areas so designated by the District Engineer. Unclaimed or unattended animals are subject to immediate impoundment and removal in accordance with state and local laws.

(b) Persons bringing or allowing pets in designated public use areas shall be responsible for proper removal and disposal, in sanitary facilities, of any waste produced by these animals.

(c) No person shall bring or allow horses, cattle, or other livestock in camping, picnicking, swimming or other recreation areas except in areas designated by the District Engineer.

(d) Ranging, grazing, watering or allowing livestock on project lands and waters is prohibited except when authorized by lease, license or other written agreement with the District Engineer.

(e) Unauthorized livestock are subject to impoundment and removal in accordance with Federal, state and local laws.

(f) Any animal impounded under the provisions of this section may be confined at a location designated by the District Engineer, who may assess a reasonable impoundment fee. This fee shall be paid before the impounded animal is returned to its owner(s).

**§ 327.12 Restrictions.**

(a) The District Engineer may establish and post a schedule of visiting hours and/or restrictions on the public use of a project or portion of a project. The District Engineer may close or restrict the use of a project or portion of a project when necessitated by reason of public health, public safety, maintenance, or other reasons in the public interest. Entering or using a project in a manner which is contrary to the schedule of visiting hours, closures or restrictions is prohibited.

(b) Quiet shall be maintained in all public use areas between the hours of 10 p.m. and 6 a.m., or those hours designated by the District Engineer. Excessive noise during such times which unreasonably disturbs persons is prohibited.

(c) Any act or conduct by any person which interferes with, impedes or disrupts the use of the project or impairs the safety of another person is prohibited. Individuals who are boisterous, rowdy, disorderly or otherwise disturb the peace on project lands or waters may be requested to leave the project.

(d) The operation or use of any audio or other noise producing device including, but not limited to, radios, televisions, or musical instruments and motorized equipment, including vessels or vehicles, in such a manner as to unreasonably annoy or endanger persons at any time or exceed state or local laws governing noise levels from motorized equipment is prohibited.

**§ 327.13 Explosives, firearms, other weapons and fireworks.**

The possession of loaded firearms, ammunition, loaded projectile firing devices, bows and arrows, crossbows, explosives or explosive devices of any kind, including fireworks, is prohibited unless: (a) In the possession of a Federal, state or local law enforcement officer; (b) being used for hunting or fishing as permitted under § 327.8, with devices being unloaded when transported to, from or between hunting and fishing sites; (c) being used at authorized shooting ranges; or (d) written permission has been received from the District Engineer.

**§ 327.14 Public property.**

(a) Destruction, injury, defacement, removal or any alteration of public property including, but not limited to, developed facilities, natural formations, mineral deposits, historical and archaeological features, and vegetative growth, is prohibited except when in accordance with written pemission of the District Engineer.

(b) Cutting or gathering of trees or parts of trees and/or the removal of wood from project lands is prohibited without written permission of the District Engineer.

(c) Gathering of dead wood on the ground for use in designated recreation areas as firewood is permitted.

**§ 327.15 Abandonment and impoundment of personal property.**

(a) Personal property of any kind shall not be abandoned, stored or left unattended upon project lands or waters. After a period of 24 hours, or at any time after a posted closure hour in a public use area, unattended personal property shall be presumed to be abandoned and may be impounded and stored at a storage point designated by the District Engineer, who may assess a reasonable impoundment fee. Such fee shall be paid before the impounded property is returned to its owner.

(b) The District Engineer shall, by public or private sale or otherwise, dispose of all lost, abandoned or unclaimed personal property that comes into Government custody or control. However, property may not be disposed of until diligent effort has been made to find the owner, heirs, next of kin or legal representative(s). If the owner, heirs, next of kin or legal representative(s) are determined but not found, the property may not be disposed of until the expiration of 120 days after the date when notice, giving the time and place of the intended sale or other disposition, has been sent by certified or registered mail to that person at the last known address. When diligent efforts to determine the owner, heirs, next of kin or legal representative(s) are unsuccessful, the property may be disposed of without delay except that if it has a fair market value of $25 or more the property may not be disposed of until 90 days after the date it is received at the storage point designated by the District Engineer. The net proceeds from the sale of property shall be covered into the Treasury of the United States as miscellaneous receipts.

(c) Personal property placed on Federal lands or waters adjacent to a private residence and/or developments of any private nature for more than 24 hours without permssion of the District Engineer shall be presumed to have been abandoned and, unless proven otherwise, such presumption will be sufficient to issue a citation as provided for in § 327.25.

**§ 327.16 Lost and found articles.**

All articles found shall be deposited by the finder at the Resource Manager's office or with a ranger. All such articles shall be disposed of in accordance with the procedures set forth in § 327.15.

**§ 327.17 Advertisement.**

Advertising by the use of billboards, signs, markers, audio devices, handbills, circulars, posters, or any other means whatsoever, is prohibited without written permission of the District Engineer. Vessels and vehicles with semipermanent or permanent painted or installed signs are exempt as long as they are used for authorized recreational activities and comply with all other rules and regulations pertaining to vessels and vehicles.

**§ 327.18 Commercial activities.**

The engaging in or solicitation of business without the express written permission of the District Engineer is prohibited.

**§ 327.19 Permits.**

(a) It shall be a violation of these regulations to refuse to or fail to comply with the fee requirements or other terms or conditions of any permit issued under the provisions of this Part 327.

(b) Permits for floating structures (issued under the authority of § 327.30) of any kind on/in waters of water resources development projects, whether or not such waters are deemed navigable waters of the United States but where such waters are under the management of the Corps of Engineers, shall be issued at the discretion of the District Engineer under the authority of this regulation. District Engineers will delineate those portions of the navigable waters of the United States where this provision is applicable and post notices of this designation in the vicinity of the appropriate Resource Manager's office.

(c) Permits for nonfloating structures (issued under the authority of § 327.30) of any kind constructed, placed in or affecting waters of water resource development projects where such waters are deemed navigable waters of the U.S. shall be issued under the provisions of section 10 of the Act approved March 3, 1899 (33 U.S.C. 403). If a discharge of dredged or fill material in these waters is involved, a permit is required under section 404 of the Clean Water Act (33 U.S.C. 1344). (See 33 CFR Parts 320–330).

(d) Permits for nonfloating structures (issued under the authority of § 327.30) of any kind in waters of water resource development projects, where such waters are under the management of the Corps of Engineers and where such waters are not deemed navigable waters of the United States shall be issued as set forth in paragraph (b) of this section. If a discharge of dredged or fill material into any water of the United States is involved, a permit is required under Section 404 of the Clean Water Act (33 U.S.C. 1344) (See 33 CFR Parts 320–330). Certification may be required pursuant to section 401 of the Clean Water Act (33 U.S.C. 1341).

**§ 327.20 Unauthorized structures.**

The construction, placement, or existence of any structure (including, but not limited to, roads, trails, signs or landscape features) of any kind under, upon, in or over the project lands or waters is prohibited unless a permit, lease, license or other appropriate written agreement has been issued by the District Engineer. The design, construction, placement, existence or use of structures in violation of the terms of the permit, lease, license or other written agreement is prohibited. The government shall not be liable for the loss of, or damage to, any private structures, whether authorized or not, placed on project lands or waters. Unauthorized structures are subject to summary removal or impoundment by the District Engineer.

**§ 327.21 Special events.**

(a) Special events including, but not limited to, water carnivals, boat regattas, music festivals, dramatic presentations or other special recreation programs are prohibited unless written permission has been granted by the District Engineer. An appropriate fee may be charged under the authority of § 327.23.

(b) The public shall not be charged any fee by the sponsor of such event unless the District Engineer has approved in writing (and the sponsor has properly posted) the proposed schedule of fees. The District Engineer shall have authority to revoke permission and require rembval of any equipment upon failure of the sponsor to comply with terms and conditions of the permit/permission or the regulations in this Part 327.

**§ 327.22 Unauthorized occupation.**

(a) Occupying any lands, buildings, vessels or other facilities within water resource development projects for the purpose of maintaining same as a full- or part-time residence without the written permission of the District Engineer is prohibited. The provisions of this section shall not apply to the occupation of lands for the purpsose of camping, in accordance with the provisions of § 327.7.

(b) Use of project lands or waters for agricultural purposes is prohibited except when in compliance with terms and conditions authorized by lease, license or other written agreement issued by the District Engineer.

**§ 327.23 Recreation use fees.**

(a) In accordance with 16 USC 4601, the Corps of Engineers is required to collect special recreation use fees and/or special permit fees for the use of specialized sites, facilities, equipment or services related to outdoor recreation furnished at Federal expense.

(b) All use fees shall be fair and equitable and will be based on the following criteria (as contained in the Land and Water Conservation Fund Act of 1965, Pub. L. 88–578, as amended):

(1) The direct and indirect amount of Federal expenditure.

(2) The benefit to the recipient.

(3) The public policy or interest served.

(4) The comparable recreation fees charged by other Federal and non-Federal public agencies and the private sector within the service area of the management unit at which the fee is charged.

(5) The economic and administrative feasibility of fee collection.

(6) The extent of regular maintenance required.

(7) Other pertinent factors.

Based upon the above criteria, it shall be the policy of the Chief of Engineers to publish in the **Federal Register**, as a general notice document, the established range of fees for specialized sites, facilities, equipment or services whenever such fees are adjusted.

(c) Where such fees are charged, the District Engineer shall insure that clear notice of fee requirements is prominently posted at each area, and at appropriate locations therein and that the notice be included in publications distributed at such areas. Failure to pay authorized recreation use fees as established pursuant to Pub. L. 88–578, 78 Stat. 897, as amended (16 U.S.C. 4601-6a), is prohibited and is punishable by a fine of not more than $100.

(d) Any Golden Age or Golden Access Passport permittee shall be entitled, upon presentation of such a permit, to utlilize special recreation facilities at a rate of 50 percent off the established use fee at Federally operated areas.

(e) At each Corps lake or reservoir where camping is permitted, the District Engineer will provide at least one primitive campground, containing designated campsites, sanitary facilities and vehicular access, where no fees will be charged.

**§ 327.24 Interference with government employees.**

(a) It is a Federal crime pursuant to the provisions of sections 1114 and 111 of Title 18, United States Code, to forcibly assault, resist, oppose, impede, intimidate, or interfere with any civilian official or employee of the U.S. Army Corps of Engineers engaged in the performance of his or her official duties, or on account of the performance of his or her official duties. Such actions or interference directed against a Federal employee while carrying out these regulations are also a violation of these regulations and may be a state crime pursuant to the laws of the state where they occur.

(b) Failure to comply with a lawful order issued by a Federal employee acting pursuant to these regulations shall be considered as interference with that employee while engaged in the performance of their official duties. Such interference with a Federal employee includes failure to provide a correct name, address or other identification upon request of the Federal employee, when that employee is authorized by the District Engineer to issue citations in the performance of the employees official duties.

**§ 327.25 Violation of rules and regulations.**

(a) Any person who violates the provisions of these regulations, other than for a failure to pay authorized recreation use fees as separately provided for in § 327.23, may be punished by a fine of not more than $500 or imprisonment for not more than six months or both and may be tried and sentenced in accordance with the provisions of section 3401 of Title 18, United States Code. Persons designated by the District Engineer shall have the authority to issue a citation for violation of these regulations, requiring the

appearance of any person charged with the violation to appear before the United States Magistrate within whose jurisdiction the affected water resources development project is located. (16 U.S.C. 460d).

(b) Any person who commits an act against any official or employee of the U.S. Army Corps of Engineers that is a crime under the provisions of section 1114 or section 111 of Title 18, United States Code or under provisions of pertinent state law may be tried and sentenced as further provided in Federal or state law, as the case may be.

**§ 327.26 State and local laws.**

Except as otherwise provided herein or by Federal law or regulation, state and local laws and ordinances shall apply on project lands and waters. This includes, but is not limited to, state and local laws and ordinances governing:

(a) Operation and use of motor vehicles, vessels, and aircraft;

(b) Hunting, fishing and trapping;

(c) Use of firearms or other weapons;

(d) Civil disobedience and criminal acts; and,

(e) Littering, sanitation and pollution.

These state and local laws and ordinances are enforced by those state and local enforcement agencies established and authorized for that purpose.

Dated: August 21, 1985.

Approved:

**Paul W. Taylor**

*Colonel, Corps of Engineers Executive Director, Engineer Staff (Chief of Staff).*

[FR Doc. 85-20946 Filed 8-30-85; 8:45 am]

BILLING CODE 3710-92-M

## ENVIRONMENTAL PROTECTION AGENCY

### 40 CFR Part 81

**[EPA Docket No. 107-VA-6; A-3-FRC-2889-8]**

### Air Quality Planning Purposes; Approval of Section 107 Designation for the Commonwealth of Virginia With Respect to Carbon Monoxide

**AGENCY:** Environmental Protection Agency.

**ACTION:** Final rule.

**SUMMARY:** This notice announces EPA's approval of an air quality designation change for Fairfax County in Virginia, from "Does not meet primary standards" to "Cannot be classified or better than national standards," for the primary and secondary National Ambient Air Quality Standards (NAAQS) for carbon monoxide (CO). This revision is based on eight consecutive calendar quarters of air quality data submitted by Virginia demonstrating attainment. EPA is approving this redesignation request because it meets the necessary requirements of section 107 of the Clean Air Act and conforms to current EPA policy.

**EFFECTIVE DATE:** October 3, 1985.

**ADDRESSES:** Copies of the revision and accompanying documents are available for public inspection during normal business hours at the following locations:

U.S. Environmental Protection Agency, Region III, Air Programs Branch (3AM10), 841 Chestnut Building, Philadelphia, PA 19107, Attn: Patricia Gaughan (3AM11)

Virginia State Air Pollution Control Board, Room 801, Ninth Street Office Building, Richmond, Virginia 23219, Attn: James Watson

**FOR FURTHER INFORMATION CONTACT:** Harold A. Frankford, 215/597-1325, or Cynthia H. Stahl, 215/597-9337, at the EPA Region III address above. The commercial and FTS phone numbers are the same.

**SUPPLEMENTARY INFORMATION:** On November 20, 1984, the Commonwealth of Virginia State Air Pollution Control Board submitted a request to redesignate three municipalities in the Northern Virginia portion of the National Capital Interstate AQCR as attainment areas for carbon monoxide (CO) under section 107 of the Clean Air Act. These municipalities are Alexandria City, Arlington County, and Fairfax County. However, recent data shows violations of the 8-hour CO standard in Alexandria City and Arlington County. Therefore, on March 18, 1985, Virginia requested that EPA only consider Fairfax County for redesignation. EPA proposed approval of the Fairfax County redesignation on April 17, 1985 (50 FR 15187). No comments were received by EPA.

This redesignation changes the carbon monoxide classification from "Does not meet primary standards" to "Cannot be classified or better than national standards" under 40 CFR 81.347 for Fairfax County. All other air quality designations for carbon monoxide remain unchanged.

There are four monitoring stations in Fairfax County: Two inside the Beltway and two outside the Beltway. The air quality data from January 1980 through December 1984 submitted by the Commonwealth show that none of the monitoring stations in this county recorded violations of the National Ambient Air Quality Standards (NAAQS) for CO. EPA has examined the air quality data collected from the monitoring sites on which this redesignation request is based and has determined that the data were collected in accordance with all EPA requirements. Accordingly, EPA is approving the Commonwealth's request for redesignation of Fairfax County with respect to CO. EPA has approved the CO contol strategy applicable to Fairfax County as part of the federally enforceable Virgina SIP. See 49 FR 3083 (1984). However, because this same control strategy is also designed to provide for attainment of the NAAQS for ozone, and because Fairfax County remains a nonattainment area for ozone, this redesignation does not change any current requirements of Virginia's approved SIP.

On April 17, 1985, EPA published a proposed rulemaking notice (50 FR 15187) in which the Agency proposed approving the redesignation. EPA did not receive any comments regarding the proposed redesignation for Fairfax County as a result of the Federal Register Notice.

### Conclusion

The Administrator's decision to approve this section 107 redesignation for Fairfax County is based on a determination that it meets the requirements of section 107 of the Clean Air Act and current EPA policy pertaining to redesignation requests.

### Procedural Information

The Office of Management and Budget has exempted this rule from the requirements of section 3 of Executive Order 12291.

Under section 307(b)(1) of the Clean Air Act, judicial review of this action is available only by the filing of a petition for review in the United States Court of Appeals for the appropriate circuit within the 60 days following September 3, 1985. Under section 307(b)(2) of the Act, the requirements which are the subject of today's Notice may not be challenged later in civil or criminal proceedings brought by EPA to enforce these requirements.

### List of Subjects in 40 CFR Part 81

Air pollution control, Intergovernmental relations.

Dated: August 23, 1985.

**Lee M. Thomas,**

*Administrator.*

### PART 81—[AMENDED]

Part 81 of Chapter I, Title 40 of the Code of Federal Regulations is amended as follows:

1. The authority citation for Part 81 continues to read as follows:

**Authority:** 42 U.S.C. 7401–7642.

2. In § 81.347 the entry for Fairfax County in the attainment status designation table for carbon monoxide is revised to read as follows:

**§ 81.347 Virginia.**

VIRGINIA–CO

| Designated area | Does not meet primary standards | Cannot be classified or better than national standards |
|---|---|---|
| . . . . . | | |
| Fairfax County—Areas of high traffic density. | X. | |
| . . . . . | | |

[FR Doc. 85–20922 Filed 8–30–85; 8:45 am]

BILLING CODE 6560–50–M

## FEDERAL COMMUNICATIONS COMMISSION

### 47 CFR Part 73

**[MM Docket No. 84–717; RM–4711]**

### FM Broadcast Station in Linden, AL

**AGENCY:** Federal Communications Commission.

**ACTION:** Final rule.

**SUMMARY:** Action taken herein allots Channel 296A to Linden, Alabama, as that community's second local FM broadcast service, in response to a petition filed by Larry G. Fuss, Sr.

**EFFECTIVE DATE:** October 4, 1985.

**ADDRESS:** Federal Communications Commission, Washington, D.C. 20554.

**FOR FURTHER INFORMATION CONTACT:** Nancy V. Joyner, Mass Media Bureau, (202) 634–6530.

**SUPPLEMENTARY INFORMATION:**

**List of Subjects in 47 CFR Part 73**

Radio broadcasting.

The authority citation for Part 73 continues to read:

**Authority:** Secs. 4 and 303, 48 Stat. 1066, as amended, 1082, as amended; 47 U.S.C. 154, 303. Interpret or apply secs. 301, 303, 307, 48 Stat. 1081, 1082, as amended, 1083, as amended, 47 U.S.C. 301, 303, 307. Other statutory and executive order provisions authorizing or interpreted or applied by specific sections are cited to text.

**Report and Order (Proceeding Terminated)**

In the matter of amendment of § 73.202(b), table of allotments, FM broadcast stations (Linden, Alabama); MM Docket No. 84–717, RM–4711.

Adopted: August 13, 1985.
Released: August 28, 1985.

By the Chief, Policy and Rules Division.

1. The Commission herein considers the *Notice of Proposed Rule Making* 49 FR 30757, published August 1, 1984, issued in response to a petition filed by Larry G. Fuss, Sr. ("petitioner") proposing the allotment of Channel 296A to Linden, Alabama as that community's second local FM broadcast service. Supporting comments were filed by petitioner in which he reiterated his intention to apply for the channel.

2. We believe the public interest would be served by allotting Channel 296A to Linden, Alabama, since it could provide a second local FM service to the community for the expression of diverse viewpoints and programming.

3. As indicated in the *Notice*, Channel 296A can be allotted to Linden in conformity with the minimum distance separation requirements of § 73.207 of the Commission's Rules, provided the transmitter is located approximately 8 kilometers (5 miles) southwest of the community to avoid short spacing to FM Station WKXX (Channel 295), Birmingham, Alabama.

**PART 73—[AMENDED]**

**§ 73.202 [Amended]**

4. Accordingly, pursuant to the authority contained in sections 4(i), 5(c)(1), 303 (g) and (r) and 307(b) of the Communications Act of 1934, as amended, and § 0.61, 0.204(b) and 0.283 of the Commission's Rules, it is ordered, That effective October 4, 1985, the FM Table of Allotments, Section 73.202(b) of the Commission's Rules, is amended to include the community listed below, as follows:

| City | Channel No. |
|---|---|
| Linden, Alabama | 275A, 296A |

5. The filing window period for filing applications on channel 296A will open on October 7, 1985 and close on November 4, 1985.

6. It is further ordered, that this proceeding is terminated.

7. For further information concerning the above, contact Nancy V. Joyner, Mass Media Bureau, (202) 634–6530.

Federal Communications Commission.

**Charles Schott,**

*Chief, Policy and Rules Division, Mass Media Bureau.*

[FR Doc. 85–20883 Filed 8–30–85; 8:45 am]

BILLING CODE 6712–01–M

## INTERSTATE COMMERCE COMMISSION

### 49 CFR Ch. X

**[Ex Parte No. 347 (Sub-1)]**

### Coal Rate Guidelines, Nationwide

**AGENCY:** Interstate Commerce Commission.

**ACTION:** Statement of General Policy.

**SUMMARY:** The Interstate Commerce Commission has announced the policies by which it will be guided in determining the reasonableness of rail captive coal rates investigated under 49 U.S.C. 10707 or challenged under 49 U.S.C. 10701a. A captive coal shipper should not be required to pay more than is necessary for the rail carrier(s) involved to earn adequate revenues. Nor should it pay more than is necessary for efficient service. A captive coal shipper should not bear the costs of any facilities or services from which it derives no benefit. Responsibility for payment for facilities or services which are shared (to its benefit) by other shippers should be apportioned according to the demand elasticities of the various shippers. Thus railroads would be given incentives to ensure that competitive traffic contributes as much as possible toward these costs. Finally, changes in coal rates should not be so precipitous as to cause severe economic dislocations. The Commission refers to these policies as "Constrained Market Pricing."

**EFFECTIVE DATE:** The policy statement will be effective on October 3, 1985.

**FOR FURTHER INFORMATION CONTACT:** Leslie J. Selzer (202) 275–7627.

**SUPPLEMENTARY INFORMATION:** Additional information is contained in the Commission's decision. To purchase a copy of the decision, write TS Info System, Inc., Room 2229, Interstate Commerce Commission Building, Washington, D.C. 20423, or call 289–4357 (DC Metropolitan Area) or toll free (800) 424–5403.

**Authority:** 5 U.S.C. 553 and 49 U.S.C. 10321, 10701a, 10704, 10707, and 11701.

Decided: August 8, 1985.

By the Commission, Chairman Taylor, Vice Chairman Gradison, Commissioners Sterrett, Andre, Simmons, Lamboley and Strenio. Chairman Taylor commented with a separate expression. Commissioner Simmons commented with a separate expression. Commissioner Lamboley concurred with a

separate expression. Commissioner Strenio concurred with a separate expression.

James H. Bayne,

*Secretary.*

[FR Doc. 85-20963 Filed 8-30-85; 8:45 am]

BILLING CODE 7035-01-M

## 49 CFR Part 1085

## ICC Field Office Locations; Technical Amendments

**AGENCY:** Interstate Commerce Commission.

**ACTION:** Technical amendments to final rules.

**SUMMARY:** Part 1085 of Title 49 contains a list of ICC Field Office locations and telephone numbers that has become out of date since its publication in 1974. The purpose of this notice is to update that list.

**EFFECTIVE DATE:** September 3, 1985.

**FOR FURTHER INFORMATION CONTACT:** John W. Fristoe, (202) 275-7844.

**SUPPLEMENTARY INFORMATION:**

**List of Subjects in 49 CFR Part 1085**

Freight forwarders; Moving of household goods.

Title 49 of the Code of Federal Regulations is amended as follows:

## PART 1085—[AMENDED]

1. The authority citation for 49 CFR Part 1085 continues to read as follows:

**Authority:** 49 U.S.C. 1010.

**§ 1085.1 [Amended]**

2. The list now entitled "Interstate Commerce Commission Field Office Locations and Telephone Numbers" that follows § 1085.1 is revised to read as follows:

INTERSTATE COMMERCE COMMISSION CONTACT OFFICES

| Address and telephone number | States served |
|---|---|
| Interstate Commerce Commission, 150 Causeway Street, Room 501, Boston, MA 02114, (617) 223-2372. | CT, ME, MA, NH, NJ, NY, RI, VT. |
| Interstate Commerce Commission, Gateway Building, 3535 Market Street, Room 16400, Philadelphia, PA 19104, (215) 596-4040. | DE, DC, MD, OH, PA, VA, WV. |
| Interstate Commerce Commission, 1776 Peachtree Street, NW., Room 300, Atlanta, GA 30309, (404) 881-2167. | AL, FL, GA, KY, MS, NC, SC, TN. |
| Interstate Commerce Commission, Everett McKinley Dirksen Building, 219 South Dearborn St., Room 1304, Chicago, IL 60604, (312) 353-6204. | IL, IN, MI, MN, ND, SD, WI. |
| Interstate Commerce Commission, 411 West Seventh Street, Suite 500, Forth Worth, TX 76102, (817) 334-3961. | AR, IA, KS, LA, MO, NE, OK, TX. |
| Interstate Commerce Commission, 211 Main Street, Suite 500, San Francisco, CA 94105, (415) 974-7125. | AK, AZ, CA, CO, ID, MT, NV, NM, OR, UT, WA, WY. |

James H. Bayne,

*Secretary.*

[FR Doc. 85-20961 Filed 8-30-85; 8:45 am]

BILLING CODE 7035-01-M

## DEPARTMENT OF THE INTERIOR

## Fish and Wildlife Service

## 50 CFR Parts 32 and 33

## Addition of Twenty National Wildlife Refuges to the Lists of Open Areas for Migratory Game Bird Hunting, Upland Game Hunting, Big Game Hunting, and/or Sport Fishing

*Correction*

In FR Doc. 85-20271 beginning on page 34478 in the issue of Monday, August 26, 1985, make the following correction:

On page 34481, first column, third complete paragraph, first line, "Fewer" should have read "Few".

BILLING CODE 1505-01-M

## DEPARTMENT OF COMMERCE

## National Oceanic and Atmospheric Administration

## 50 CFR Part 630

**[Docket No. 50581-5127]**

## Atlantic Swordfish Fishery

*Correction*

In FR Doc. 85-20142 beginning on page 33952 in the issue of Thursday, August 22, 1985, make the following corrections:

**§ 630.2 [Corrected]**

On page 33957, second column, in § 630.2, in the definition for *"Western North Atlantic swordfish stock"*, make the following corrections in the ninth through twelfth lines: "5' 00 N."; should read "5° 00' N."; "40' 00' W." should read "40° 00' W."; "36' 00 N." should read "36° 00' N."; "42' 00' W." should read "42° 00' W."; "59' 00' N." should read "59° 00' N."; "44' 00' W." should read "44° 00' W."

BILLING CODE 1505-01-M

# Proposed Rules

Federal Register
Vol. 50, No. 170
Tuesday, September 3, 1985

This section of the FEDERAL REGISTER contains notices to the public of the proposed issuance of rules and regulations. The purpose of these notices is to give interested persons an opportunity to participate in the rule making prior to the adoption of the final rules.

## DEPARTMENT OF AGRICULTURE

### Agricultural Marketing Service

### 7 CFR Part 999

### Specialty Crops; Import Regulations; Reopening of the Time for Receipt of Written Comments on Proposed Changes in Raisin Import Regulation

**AGENCY:** Agricultural Marketing Service, USDA.

**ACTION:** Proposed rule.

**SUMMARY:** Notice is hereby given of reopening the time period for filing written comments on a proposal to change grade requirements for imported Thompson Seedless and Monukka raisins, and to include grade requirements for Golden Seedless raisins in the import regulations. The reopening of the comment period will give interested persons additional time to analyze and submit written comments on the proposal.

**DATES:** The additional time for comments ends September 27, 1985.

**ADDRESSES:** Interested persons are invited to submit written comments concerning the proposed changes during the extended period. Comments should be sent in duplicate to the Docket Clerk, Fruit and Vegetable Division, AMS, USDA, Room 2069, South Building, Washington, D.C. 20250. Comments should reference the date and page number of the issue of the **Federal Register** and will be available for public inspection in the office of the Docket Clerk during regular business hours.

**FOR FURTHER INFORMATION CONTACT:** Frank M Grasberger, Acting Chief, Specialty Crops Branch, Fruit and Vegetable Division, AMS, USDA, Washington, D.C. 20250 (202) 447-5053.

**SUPPLEMENTARY INFORMATION:** Pursuant to the Agricultural Marketing Agreement Act of 1937 (7 U.S.C. 601-674) a notice of proposed rulemaking was published in the July 15, 1985, issue of the **Federal Register** (50 FR 28585), regarding changes in the import regulations for Specialty Crops (7 CFR Part 999). The proposal pertains to grade requirements for imported Thompson Seedless and Monukka raisins, and includes grade requirements for Golden Seedles raisins in the import regulation. The raisin import regulation (7 CFR 999.300) is effective pursuant to the requirements of section 8e of the Agricultural Marketing Agreement Act of 1937 (7 U.S.C. 601-674). That section requires the Secretary of Agriculture to issue, after reasonable notice, grade requirements on imported raisins which are the same as, or comparable to, those applied to domestic raisins under the marketing agreement and Order No. 989, both as amended (50 FR 1830). The marketing agreement and order regulate the handling of raisins produced from grapes grown in California and are also effective under the same act.

The Association of Food Industries has requested that the comment period be reopened because it had insufficient time after it received notice of the proposals to analyze and submit written comments on them. Therefore, the period for receipt of written data, views, or arguments is reopened. Written comments must be received by September 27, 1985.

**List of Subjects in 7 CFR Part 999**

Food grades and standards, Imports, Dates, Walnuts, Prunes, Raisins, and Filberts/Hazelnuts.

1. The authority citation for 7 CFR Part 999 continues to read as follows:

Authority: Secs. 1-19, 48 Stat. 31, as amended; 7 U.S.C. 601-674.

Dated: August 28, 1985.

**Thomas R. Clark,**

*Deputy Director, Fruit and Vegetable Division.*

[FR Doc. 85-20908 Filed 8-30-85; 8:45 am]

BILLING CODE 3410-02-M

### Animal and Plant Health Inspection Service

### 9 CFR Part 77

**[Docket No. 85-021]**

### Tuberculosis in Cattle; State Designations

**AGENCY:** Animal and Plant Health Inspection Service, USDA.

**ACTION:** Proposed rule.

**SUMMARY:** This document proposes to amend the regulations governing the interstate movement of cattle because of tuberculosis. It is proposed to raise the designation of Arizona, Delaware, Indiana, Kansas, Massachusetts, Michigan, Nebraska, Nevada, New York, Oklahoma, Pennsylvania, South Carolina, South Dakota, Vermont, and the Virgin Islands of the United States from modified accredited areas to accredited-free States. It has been determined that these jurisdictions meet the criteria for designation as accredited-free States. It also proposed to lower the designation of North Carolina from an accredited-free State to a modified accredited area. It has been determined that North Carolina no longer meets the criteria for designation as an accredited-free State but meets the criteria for designation as a modified accredited area.

The regulations do not impose restrictions on the interstate movement of cattle not known to be affected with or exposed to tuberculosis from either accredited-free States or modified accredited areas. However, the designation for any given jurisdiction can affect the marketability of cattle from that jurisdiction, since some prospective cattle buyers prefer to buy cattle from accredited-free States.

**DATE:** Written comments must be received on or before November 4, 1985.

**ADDRESSES:** Written comments concerning this proposed rule should be submitted to Thomas O. Gessel, Director, Regulatory Coordination Staff, APHIS, USDA, Room 728, Federal Building, 6505 Belcrest Road, Hyattsville, MD 20782. Comments should state that they are in response to Docket Number 85-021. Written comments received may be inspected at Room 728 of the Federal Building between 8 a.m. and 4:30 p.m., Monday through Friday, except holidays.

**FOR FURTHER INFORMATION CONTACT:** Dr. Ralph L. Hosker, Cattle Diseases Staff, VS, APHIS, USDA, Room 818, Federal Building, 6505 Belcrest Road, Hyattsville, MD 20782, 301-436-8715.

**SUPPLEMENTARY INFORMATION:**

**Background**

The "Tuberculosis in Cattle" regulations (contained in 9 CFR Part 77 and referred to below as the regulations) regulate the interstate movement of

cattle because of tuberculosis. The requirements of the regulations concerning the interstate movement of cattle not known to be affected with or exposed to tuberculosis are based on whether the cattle are moved from jurisdictions designated as accredited-free States, modified accredited areas, or nonmodified accredited areas. The criteria for determining the status of States (the term State is defined to mean any State, territory, the District of Columbia, or Puerto Rico) or portions of States is contained in the document captioned "Uniform Methods and Rules—Bovine Tuberculosis Eradication," which has been made part of the regulations by incorporation by reference. Generally the status of States or portions of States is determined based on the rate of tuberculosis infection present and the effectiveness of a tuberculosis control and eradication program.

Sections 77.7 and 77.8 of the regulations provide the following with respect to the interstate movement of cattle not known to be affected with or exposed to tuberculosis:

*Section 77.7 Movement from accredited-free States and modified accredited areas.*

Cattle not known to be affected with or exposed to tuberculosis, originating in an accredited-free State or a modified accredited area, may be moved interstate without restriction.

*Section 77.8 Movement from nonmodified accredited areas.*

Cattle not known to be affected with or exposed to tuberculosis, originating in a nonmodified accredited area, shall only be moved interstate if:

(a) Such cattle are accompanied by a certificate stating that such cattle have been classified negative to an official tuberculin test, which was conducted within 30 days prior to the date of movement. All cattle not individually identified by a registration name and number shall be individually identified by a Veterinary Services approved metal eartag or tattoo; or

(b) Such cattle are from an accredited herd and they are accompanied by a certificate showing the cattle to be from such a herd; or

(c) Such cattle are moved interstate directly to slaughter to an establishment operating under the provisions of the Federal Meat Inspection Act (21 U.S.C. 601 *et seq.*) or to a State inspected slaughtering establishment which has inspection by a State inspector at the time of slaughter.

Arizona, Delaware, Indiana, Kansas, Massachusetts, Michigan, Nebraska, Nevada, New York, Oklahoma, Pennsylvania, South Carolina, South Dakota, Vermont, and the Virgin Islands of the United States, among other States, are designated under § 77.5 of the regulations as modified accredited areas. The Deputy Administrator has determined that these jurisdictions meet the criteria for designation as accredited-free States. Therefore, it is proposed to amend the regulations by adding these jurisdictions to the list of accredited-free States in § 77.4.

Also, North Carolina is included in the list of jurisdictions designated in § 77.4 of the regulations as accredited-free States. The Deputy Administrator has determined that North Carolina no longer meets the criteria for designation as an accredited-free State, but instead meets the criteria for designation as a modified accredited area. Therefore, it is proposed to amend the regulations to designate North Carolina as a modified accredited area.

As noted above, the regulations do not impose restrictions on the interstate movement of cattle not known to be affected with or exposed to tuberculosis from accredited-free States or modified accredited areas. However, the designation for any given jurisdiction can affect the marketability of cattle from that jurisdiction, since some prospective cattle buyers often prefer to buy cattle from accredited-free States.

**Executive Order and Regulatory Flexibility Act**

This proposed rule is issued in conformance with Executive Order 12291 and has been determined to be not a major rule. Based on information compiled by the Department, it has been determined that this proposed rule if adopted, would not have a significant effect on the economy; would not cause a major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; and would not have any significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

For this action, the Office of Management and Budget has waived its review process required by Executive Order 12291.

Cattle moved interstate are moved for slaughter, for use a breeding stock, or for feeding. It has been determined that the adoption of the proposed rule would not cause a significant effect on marketing patterns and would not have a significant economic impact on those persons affected by this document.

Under these circumstances, the Administrator of the Animal and Plant Health Inspection Service has determined that this action would not have a significant impact on a substantial number of small entities.

**Executive Order 12372**

This program/activity is listed in the Catalog of Federal Domestic Assistance under No. 10.025 and is subject to the provisions of Executive Order 12372 wich requires intergovernmental consultation with State and local officials. (See 7 CFR 3015, Subpart V, 48 FR 29112, June 24, 1983; 49 FR 22675, May 31, 1984; 50 FR 14088, April 10, 1985).

**List of Subjects in 9 CFR Part 77**

Animal Diseases, Cattle, Transportation, Tuberculosis.

## PART 77—TUBERCULOSIS IN CATTLE

Accordingly, it is proposed to amend 9 CFR Part 77 as follows:

1. The authority citation for Part 77 would be revised to read as set forth below:

**Authority:** 21 U.S.C. 111, 114, 114a, 115–117, 120, 121, 134b, 134f; 7 CFR 2.17, 2.51, and 371.2(d).

2. In § 77.4, paragraph (b) would be revised to read as follows:

**§ 77.4 Accredited-free States.**

* * * * *

(b) The following States are hereby designated accredited-free States: Arizona, Colorado, Connecticut, Delaware, Indiana, Kansas, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Utah, Vermont, Wyoming, and the Virgin Islands of the United States.

Done at Washington, D.C., this 27th day of August 1985.

J.K. Atwell,

*Deputy Administrator, Veterinary Services.*

[FR Doc. 85-20948 Filed 8-30-85; 8:45 am]

BILLING CODE 3410-34-M

## FEDERAL TRADE COMMISSION

**16 CFR Part 13**

**[Dkt. 9177]**

**Columbia Enterprises, Inc., et al.; Proposed Consent Agreement With Analysis To Aid Public Comment**

**AGENCY:** Federal Trade Commission.

**ACTION:** Proposed Consent Agreement.

**SUMMARY:** In settlement of alleged violations of federal law prohibiting unfair acts and practices and unfair methods of competition, this consent

agreement, accepted subject to final Commission approval, would require a Tulsa, Okla., producer and distributor of carbon black, a component in the manufacture of natural and synthetic rubber, among other things, to obtain Federal Trade Commission approval before acquiring substantial assets or stock in its competitors' production facilities. Such approval would be needed if the total acquisitions over a five year period would increase the respondent's yearly carbon black production capacity by 130 million pounds or more.

**DATE:** Comments must be received on or before November 4, 1985.

**ADDRESS:** Comments should be addressed to: FTC/Office of the Secretary, Room 136, 6th St. and Pa. Ave., NW., Washington, D.C. 20580.

**FOR FURTHER INFORMATION CONTACT:** FTC/L-502, Edward F. Glynn, Jr., Washington, D.C. 20580. (202) 634-6608.

**SUPPLEMENTARY INFORMATION:** Pursuant to Section 6(f) of the Federal Trade Commission Act, 38 Stat. 721, 15 U.S.C. 46 and § 3.25(f) of the Commission's Rules of Practice (16 CFR 3.25(f)), notice is hereby given that the following consent agreement containing a consent order to cease and desist, having been filed with and accepted, subject to final approval, by the Commission, has been placed on the public record for a period of sixty (60) days. Public comment is invited. Such comments or views will be considered by the Commission and will be available for inspection and copying at its principal office in accordance with § 4.9(b)(14) of the Commission's Rules of Practice (16 CFR 4.9(b)(14)).

**List of Subjects in 16 CFR Part 13**

Rubber carbon black, Trade practices.

**United States of America Before Federal Trade Commission**

In the Matter of Columbian Enterprises, Inc. et al.

[Docket No. 9177]

*Agreement Containing Consent Order*

The agreement herein, by and between the corporation Columbian Enterprises, Inc. by its duly authorized officer, and counsel for the Federal Trade Commission, is entered into in accordance with the Commission's Rules governing consent order procedures. In accordance with those rules the parties hereby agree that:

1. Respondent Columbian Enterprises, Inc. is a corporation organized and existing under the laws of the State of New York with its corporate headquarters at 425 Park Avenue, New York, New York 10002.

2. Respondent has been served with a copy of the complaint issued by the Federal Trade Commission (the "Commission") charging it with violation of section 7 of the Clayton Act, as amended (15 U.S.C. 18), and section 5 of the Federal Trade Commission Act, as amended (15 U.S.C. 45), and has filed an answer to said complaint denying said charges.

3. Respondent admits all the jurisdictional facts set forth in the Commission's complaint in this proceeding.

4. Respondent waives:

(a) Any further procedural steps;

(b) The requirement that the Commission's decision contain a statement of findings of fact and conclusions of law;

(c) All rights to seek judicial review or otherwise to challenge or contest the validity of the order entered pursuant to this agreement; and

(d) Any claim under the Equal Access to Justice Act.

5. This agreement shall not become a part of the public record of the proceeding unless and until it is accepted by the Commission. If this agreement is accepted by the Commission, it will be placed on the public record for a period of sixty (60) days and information in respect thereto publicly released. The Commission thereafter may either withdraw its acceptance of this agreement and so notify the respondent, in which event it will take such action as it may consider appropriate, or issue and serve its decision in accordance with the terms of this agreement in disposition of the proceeding.

6. This agreement is for settlement purposes only and does not constitute an admission by respondent that the law has been violated as alleged in the complaint issued by the Commission.

7. This agreement contemplates that, if it is accepted by the Commission, and if such acceptance is not subsequently withdrawn by the Commission pursuant to the provisions of § 3.25(f) of the Commission's Rules, the Commission may without further notice to respondent, (1) issue its decision containing the following order to cease and desist in disposition of the proceeding, and (2) make information public in respect thereto. When so entered, the order shall have the same force and effect any may be altered, modified or set aside in the same manner and within the same time provided by statute for other orders. The order shall become final upon service. Delivery by the U.S. Postal Service of the decision containing the agreed-to order to respondent's address as stated in this agreement shall constitute service. Respondent waives any right it might have to any other manner of service. The complaint may be used in construing the terms of the order, and no agreement, understanding, representation, or interpretation not contained in the order or in the agreement may be used to vary or to contradict the terms of the order.

8. Respondent has read the complaint and the order contemplated hereby. It understands that once the order has been issued, it will be required to file one or more compliance reports showing that it has fully complied with the order. Respondent further understands that it may be liable for civil penalties in the amount provided by law for each violation of the order after it becomes final.

*Order*

Definitions

For the purposes of this order the following definitions shall apply:

"Rubber carbon black" means furnace-process and thermal-process carbon black used for the manufacture of rubber.

"Columbian" means Columbian Enterprises, Inc., as well as its officers, employees, agents, its parents, divisions, subsidiaries, successors, assigns, and the officers, employees or agents of its parents, divisions, subsidiaries, successors and assigns.

"Rubber carbon black production capacity" means the practical annual productive capacity in the United States of rubber carbon black of any production units, including both units currently in operation and existing units that could be put into operation with or without time delay or additional investment. The term shall not include units dedicated to the manufacture of carbon black for industrial end uses. The term shall include reactor vessels, including associated nozzles and reaction chambers, and associated baghouses and dryers, but shall not include other equipment.

I

It Is Ordered, That for a period of five (5) years from either (a) the date this Order becomes final or (b) February 15, 1985, whichever is earlier, Columbian shall not acquire, directly or indirectly, without the prior approval of the Commission, any part of the United States rubber carbon black business of any other person or corporation, whether represented by securities or assets, other than products or securities obtained in the regular course of

business, if as a result of such acquisition Columbian would cumulatively increase its United States rubber carbon black production capacity by more than 130 million pounds.

II

It is further ordered, That while Paragraph I of this Order is effective, Columbian shall notify the Commission at least thirty (30) days prior to any proposed corporate change such as dissolution, assignment of substantially all assets, sale resulting in the emergence of a successor corporation, or the creation or dissolution of subsidiaries in the United States, that may affect compliance obligations arising out of this order.

III

It is further ordered, that (a) if the Commission dismisses its complaint in *Bass Brothers Enterprises, Inc., et al.*, Docket No. 9178, with respect to Respondents Bass Brothers Enterprises, Inc. or Sid Richardson Carbon & Gasoline Co., (hereinafter collectively "Richardson") then this order shall, upon application of Respondent, be dismissed, unless the Commission determines that the grounds for the dismissal of Richardson are a material change in the market for rubber carbon black or in the competitive significance of Richardson in that market, and the Commission finds that said grounds are not applicable to Columbian; (b) if the Commission proceeding in *Bass Brothers Enterprises, Inc., et al.* terminates with an order that does not require prior Commission approval of future acquisitions by Richardson or requires prior Commission approval for a period shorter than that set forth in Paragraph I above, then this Order shall, upon application of Respondent, be modified to impose only such lesser restriction on Respondent herein; and (c) if the Commission proceeding in *Bass Brothers Enterprises, Inc., et al.* terminates with an order that permits without prior Commission approval acquisitions that would cumulatively increase Richardson's United States rubber carbon black capacity by more than 130 million pounds (including any permitted acquisition of capacity by Richardson from Ashland,) then this Order shall, upon application of Respondent, be modified to permit Respondent herein to acquire United States rubber black production capacity in the same amount.

IV

It is further ordered, that if Columbian shall make an acquisition of United States rubber carbon black production capacity permitted under this Order while Paragraph I of this Order is effective, it shall file with the Commission a written report describing such acquisition.

**Analysis of Proposed Consent Order To Aid Public Comment**

The Federal Trade Commission has accepted an agreement to a proposed consent order from Columbian Enterprises, Inc.

The proposed consent order has been placed on the public record for sixty (60) days for reception of comments by interested persons. Comments received during this period will become part of the public record. After sixty (60) days, the Commission will again review the agreement and the comments received and will decide whether it should withdraw from the agreement or make final the agreement's proposed order.

The complaint, which was issued May 8, 1984, challenges, as violations of Section 7 of the Clayton Act, 15 U.S.C. 18, and Section 5 of the Federal Trade Commission Act, 15 U.S.C. 45, the proposed acquisition by Columbian Enterprises, Inc. ("Columbian") of the voting securities of Continental Carbon Company ("Concarb"), a wholly owned subsidiary of Conoco, Inc. (Concarb is now a wholly owned subsidiary of Witco Chemical Corp.) The complaint alleges that both Columbian and Concarb are substantial competitors in the United States carbon black market; that the United States carbon black market is highly concentrated, and that barriers to entry into the production and distribution of carbon black are substantial. The complaint alleges that the effects of the proposed acquisition would be to eliminate substantial actual competition between Columbian and Concarb, and eliminate Concarb as a substantial competitor in the carbon black market; to substantially increase concentration in an already highly concentrated market and encourage additional mergers or acquisitions in that market, thus increasing the likelihood of collusions; to tend to reduce the degree of price competition and to reduce the volume of production below competitive levels; and to tend to reduce the actual competition among other companies engaged in the production and distribution of carbon black. The complaint charges that the proposed acquisition constitutes a violation of section 5 of the Federal Trade Commission Act, and if consumated, would constitute a violation of Section 7 of the Clayton Act.

The proposed order requires Columbian to obtain prior Commission approval for a period of five years for acquisition of securities or assets of a competitor in the United States rubber carbon black business. The order does not cover acquisitions in the "industrial," non-rubber carbon black business. In addition, no prior approval is required if the cumulative total capacity added through acquisitions is less than 130 million annual pounds. Columbian is required to notify the Commission of any rubber carbon black acquisitions for which prior approval is not required.

The order provides that, upon application by Columbian, its terms may be modified in certain circumstances, depending on the Commission's action in the still-pending complaint against another acquisition in the carbon black industry, *Bass Brothers Enterprises, Inc.*, Docket No. 9178. If the *Bass Brothers* complaint is dismissed, then the Columbian order will also be dismissed, unless the Commission determines that the grounds for dismissal in *Bass Brothers* are a material change in the market for rubber carbon black or the competitive significance of Bass Brothers in that market, and the Commiission finds that those grounds are not applicable to Columbian. Further, if the Commission issues an order in *Bass Brothers* that does not require prior Commission approval of future acquisitions, or requires approval for a period shorter than five years, then the Columbian order will be modified to impoose the lesser restriction. Finally, if the Commission issues an order in *Bass Brothers* that permits, without prior approval, acquisitions cumulatively greater than 130 million pounds of capacity, then the Columbian order will be modified to conform to the higher threshold.

The agreement is for purposes of settlement only; it does not constitute an admission by Columbian that the law has been violated as alleged in the Complaint.

The purpose of this analysis is to facilitate public comment on the proposed order, and it is not intended to constitute an official interpretation of the agreement and proposed order or to modify in any way their terms.

**Benjamin I. Berman,**

*Acting Secretary.*

[FR Doc. 85-20944 filed 8-30-85; 8:45 am]

BILLING CODE 6750-01-M

## RAILROAD RETIREMENT BOARD

### 20 CFR Part 295

### Railroad Retirement Annuities

**AGENCY:** Railroad Retirement Board.

**ACTION:** Proposed rule.

**SUMMARY:** The Railroad Retirement Board hereby proposes rules implementing section 419 of the Railroad Retirement Solvency Act of 1983, which amended section 14 of the Railroad Retirement Act to provide that, with respect to annuity amounts payable for months beginning with September, 1983, the Board must comply with a court decree of divorce, annulment or legal separation, or with the terms of any court-approved property settlement incident to any such decree, which characterizes specified benefits as property subject to distribution. The proposed regulations add a new Part 295 to Chapter II of the Board's regulations promulgated under the Railroad Retirement Act.

**DATE:** Comments must be received on or before October 3, 1985.

**ADDRESS:** Secretary to the Board, Railroad Retirement Board, 844 Rush Street, Chicago, Illinois 60611.

**FOR FURTHER INFORMATION CONTACT:** Karl Blank, General Attorney, Railroad Retirement Board, Bureau of Law, 844 Rush Street, Chicago, Illinois 60611, (312) 751–4941 (FTS 387–4941).

**SUPPLEMENTARY INFORMATION:** Retirement and survivor annuities under the Railroad Retirement Act are composed of independently calculated segments known as tiers. The tier I amount combines both railroad and non-railroad earnings, and is calculated using social security benefit formulas. The tier II amount is calculated under different formulas, generally representing railroad earnings alone. In addition, certain annuitants receive a dual benefit component based on non-railroad wages earned through December 1974, or in some cases through an earlier date. Finally, career railroad employees may receive a supplemental annuity ranging from $23 to $43 per month.

In 1979, the United States Supreme Court held that section 14 of the Railroad Retirement Act, which generally provided that no benefit under the Act may be assigned or subjected to other legal process, prohibited a court from awarding one spouse a community interest in any benefits, whether present or expected in the future, to which the other spouse may become entitled under the Railroad Retirement Act. *Hisquierdo* v. *Hisquierdo*, 439 U.S. 572.

Section 419 of Pub. L. 98–76 (97 Stat. 411), enacted on August 12, 1983, amends section 14 of the Act by adding new section 14(b)(2), which provides that non-tier I annuity components are subject to property divisions set forth in state court divorce decrees and court-approved property settlements, effective with respect to benefits payable for months beginning in September 1983. Pursuant to section 14(b)(2), the Board will now honor a final decree of divorce, annulment or legal separation which is issued in accordance with the laws of the jurisdiction of that court and which provides for the division of benefits under the Act, to the extent that (1) the decree is intended to obligate the Board to make direct payments to the spouse or former spouse, and (2) the employee is entitled to an annuity or annuity component which is subject to division under that section (*i.e.*, a tier II, dual benefit, or supplemental annuity). Similarly, the Board will honor a court-approved property settlement incident to such a decree. As the amendment to section 14 of the Act specifically exempts the tier I annuity component from division, *Hisquierdo* remains applicable to this component.

The Board has determined that this is not a major rule under Executive Order 12291. Therefore, no regulatory analysis is required. The information collections associated with this rule have been approved by the Office of Management and Budget.

### List of Subjects in 20 CFR Part 295

Railroad employees, Railroad retirement.

Title 20 CFR Chapter II is revised as follows:

1. Title 20 CFR, Chapter II is proposed to be amended by adding a new Part 295, reading as follows:

## PART 295—PAYMENTS PURSUANT TO COURT DECREE OR COURT-APPROVED PROPERTY SETTLEMENT

Sec.



Authority: 45 U.S.C. 231f; 45 U.S.C. 231m.

### § 295.1 Introduction.

(a) *Purpose.* This part implements section 419 of Pub. L. 98–76 (97 Stat. 438), which amended section 14 of the Railroad Retirement Act to provide that, with respect to annuity amounts payable for months beginning with September 1983, the Board must comply with a court decree of divorce, annulment or legal separation, or with the terms of any court-approved property settlement incident to any such decree, which characterizes specified benefits as property subject to distribution. Garnishment of benefits for alimony or child support is dealt with in Part 350 of this chapter.

(b) *Benefits subject to this part.* Only the following benefits or portions of benefits under the Railroad Retirement Act are subject to this part:

(1) Employee annuity net tier II benefit component as provided under section 3(b) of the Railroad Retirement Act;

(2) Employee annuity vested dual benefit component as provided under section 3(h) of the Act;

(3) Employee annuity net proportionate share of the annuity increases as provided under section 3(f) of the Act; and

(4) Supplemental annuities as provided under section 2(b) of the Act.

### § 295.2 Definitions.

As used in this part—

Act means the Railroad Retirement Act.

*Court* means any court of competent jurisdiction of any state, the District of Columbia, the Commonwealth of Puerto Rico, Guam, American Samoa, the Virgin Islands, the Northern Mariana Islands, and the Trust Territory of the Pacific Island; or any court of the United States (as defined in section 451 of title 28 of the United States Code) having competent jurisdiction; or any court of competent jurisdiction of a foreign country with which the United States has an agreement requiring the United States to honor any court order of such country.

*Court Decree* means a final decree of divorce, dissolution, annulment, or legal separation issued by a court (including a final decree or order modifying the terms of a previously issued decree of divorce, dissolution, annulment, or legal separation), which is issued in accordance with the laws of the jurisdiction of that court and which provides for the division of property.

*Division of Property* means any transfer of property or its value by an individual to his or her spouse or formers spouse in compliance with any community property settlement, equitable distribution of property, or other distribution of property between spouses or former spouses, which is intended as a present and complete settlement of the property rights of the parties.

*Employee* means an individual who is or was formerly an employee as defined by Part 203 of this chapter.

*Final Decree* means a decree from which no appeal may be taken or from which no appeal has been taken within the time allowed for taking such appeals under the laws applicable to such appeals, or a decree from which timely appeal has been taken and such appeal has been finally decided under the laws applicable to such appeals.

*Property Settlement* means an agreement between the parties to a suit for divorce, dissolution, annulment or legal separation in which they expressly agree to a division of their property rights, and which is incorporated in the final decree; is filed with the court in connection with a suit for divorce, dissolution, annulment or legal separation; or is otherwise present to the court in such a suit in accordance with the law of the jurisdiction. An agreement assigning or transferring property between spouses is not within the purview of this part unless it is subsequently approved by a court in connection with a suit for divorce, dissolution, annulment or legal separation.

*Spouse of Former Spouse* means the husband or wife, or former husband or wife, respectively, of an employee who, on or before the date of a court order, was married to the employee.

**§ 295.3 Documentation and service.**

(a) *Court decree or property settlement.* The Board will honor a court decree or a property settlement which meets the following criteria:

(1) The court decree or property settlement must provide that the spouse or former spouse is award payments from railroad retirement annuities payable to the railroad employee.

(2) The court decree or property settlement must specify an amount to be paid to the spouse or former spouse.

(3) The court decree or property settlement must obligate the Board to make payments directly to the spouse or former spouse.

(4) The court decree or property settlement must clearly identify both the employee and the spouse or former spouse to whom payments are to be made.

(5) The court decree or property settlement submitted to the Board must be a recently certified copy of the document filed with the court. Where the award is made in an order modifying an earlier court decree, copies of both the original decree and the subsequent order must be furnished. In the case of a court-approved property settlement, both the settlement and any decree or order incorporating or approving the settlement must be provided.

(b) *Date of decree.* While only benefits payable for months after August, 1983 are subject to this part, the date the decree is entered or the property settlement is approved may precede September 1, 1983. A subsequent modification of a decree which was entered or property settlement which was approved prior to September 1, 1983 must be in accord with the law of the jurisdiction in which the original decree was entered or the property settlement was approved.

(c) *Supporting documentation.* The spouse or former spouse shall submit such additional documentation as the Board shall require, including but not limited to:

(1) Identifying information concerning the employee such as social security number, railroad retirement claim number, full name, date of birth, and current address.

(2) Identifying information concerning the spouse or former spouse such as social security number, full name, and current address.

(3) A statement that—

(i) No condition of the law of the jurisdiction in which the decree was entered or the property settlement approved and no condition contained in the decree or agreement which requires termination of payment has occurred;

(ii) If any such condition does occur, the spouse or former spouse will immediately notify the Board; and

(iii) The spouse or former spouse agrees to repay any erroneous payment arising from occurrence of any such condition.

(d) *Delivery.* Any court decree or property settlement must be delivered by certified or registered mail, return receipt requested, or by personal service, to the Deputy General Counsel of the Railroad Retirement Board, 844 Rush Street, Chicago, Illinois 60611. Where the decree or property settlement is delivered to any other office of the Board, it shall not be considered delivered until the date it is received by the Deputy General Counsel. Where the decree or property settlement was furnished to any office of the Board prior to September 1, 1983, delivery is not accomplished until a copy is received by the Deputy General Counsel subsequent to August 30, 1983.

(Approved by the Office of Management and Budget under Control No. 3220-0042.)

**§ 295.4 Review of documentation.**

(a) *Regularity.* The Deputy General Counsel or his or her designee shall review the court decree or property settlement to determine that it complies with both the law of the jurisdiction, and with Federal law and these regulations.

(b) *Amount.* Ambiguities in the amount to be paid the spouse or former spouse shall be resolved in accord with expressed indications of the court's intent, except that:

(1) Where the amount is expressed in terms of a dollar figure:

(i) If the figure exceeds the total benefits which may be allocated under this part, the excess will be disregarded, provided that any future increase in the benefits subject to this part will be prospectively applied to the excess effective with the date of the benefits increase.

(ii) If the figure is less than the total benefits which may be allocated under this part, only the amount specified will be paid.

(2) Where the amount is expressed as a fraction, percentage, or ratio:

(i) The amount specified shall be applied only against benefits subject to this part, irrespective of the wording of the decree or property settlement.

(ii) When the amount is expressed in terms of a fraction or ratio referring to the length of railroad service, years shall be converted into the equivalent months. If the length of railroad service specified in the decree or property settlement exceeds the number of creditable service months used by the Board to determine the employee's years of service for calculating an annuity, the actual number used by the Board shall be substituted. If the decree understates the actual number of creditable railroad service months, the number of years or months set forth in the decree or property settlement will be used.

(3) An amount may be expressed in any other fashion only to the extent to which it may be readily ascertained from records maintained by the Board in the regular course of administration of the Act.

(c) *Notification.* The Deputy General Counsel or his or her designee shall make reasonable effort to notify the spouse or former spouse and the employee of a determination that the decree or property settlement does or does not qualify as a decree or property settlement which will be honored pursuant to this part. This notice will be mailed to the most recent address of each party or representative of each party as shown in the Board's records. A copy of the decree or property settlement will be provided to the employee with this notice. The notice must state:

(1) The rationale for a determination that the decree or property settlement does not comply with this part; or

(2) The dollar amount or proportion of benefits which will be paid to the spouse or former spouse.

(d) *Withholding after notification.* (1) Where the Deputy General Counsel or his or her designee has notified the spouse or former spouse that a decree or property settlement will be honored under this part, but where the employee is not then entitled to any benefits subject to division under this part, the Associate Executive Director for Retirement Claims will notate the Board's records to reflect both the amount of benefits awarded to the spouse or former spouse pursuant to the decree or property settlement and his or her current address. Where the employee is currently entitled to benefits subject to this part, and the spouse or former spouse has furnished all additional documentation required, the Associate Executive Director for Retirement Claims will take action to withhold from the employee's monthly benefit the amount stated in the Deputy General Counsel's notice under paragraph (c) of this section that the Board will honor the decree or property settlement.

(2) Where the employee was not entitled to benefits subject to this part at the time of the notice by the Deputy General Counsel that the Board will honor the decree or property settlement, but the employee becomes so entitled at a later time, the Board will attempt to contact the spouse or former spouse at the most recent address shown in the Board's records. The notice will inform the spouse or former spouse that an annuity has been awarded, that the spouse or former spouse may, upon submission of all required documentation, receive a portion of the annuity, and that the spouse or former spouse should contact the Board within three months from the date of the notice. The Associate Executive Director for Retirement Claims will initiate withholding of the amount awarded to the spouse or former spouse from the employee's monthly benefit, and will continue to withhold this amount for three successive months; provided, that an initial annuity payment for a retroactive period shall count as one monthly benefit payment. If after the third month's payment has been withheld the Board has received no response from the spouse or former spouse, the amount withheld from the employee's benefit shall be paid to the employee, and the Board shall take no further action regarding the decree until the spouse or former spouse contacts the Board.

(3) Benefits withheld from the employee may not be paid to a spouse or former spouse until the spouse or former spouse has furnished all supporting documentation required pursuant to § 295.3 above. The Board shall allow a reasonable time, not to exceed three months from the date of the initial response from the spouse or former spouse, for the submission of all required documentation. If the documentation is not furnished within the time allowed, payment of the amounts withheld shall be made to the employee.

(4) Any payments made to the employee subsequent to the three-month notice period specified in paragraphs (d)(2) and (d)(3) above, and prior to receipt of a response or required documentation from the spouse or former spouse, shall be considered properly paid to the employee and the Board shall have no further liability to the spouse or former spouse with respect to such amounts.

**§ 295.5 Limitations.**

(a) *Employee benefit entitlement.* Payments will be made to a spouse or former spouse under this part only if the employee has been awarded an annuity under the Railroad Retirement Act. Payments to a spouse or former spouse shall be made only for months and from such amounts with respect to which an annuity is payable to the employee, and shall be suspended or terminated for any month in which the annuity of the employee is suspended or terminated. No arrearage accrues to the spouse or former spouse with respect to any month for which the annuity of the employee is suspended or reduced as required under the Act.

(b) *Minimum amount.* The amount of payment to a spouse or former spouse may not be less than one dollar per month.

(c) *Prospective payment.* Payment to a spouse or former spouse may accrue no earlier than the later of the date of delivery, pursuant to § 295.3 of this part, of a court decree or property settlement which will be honored under this part, or from October 1, 1983. The amount to be paid the spouse or former spouse under this part will not be increased to satisfy an arrearage due from the employee.

(d) *Payees.* Payment of an amount awarded to a spouse or former spouse by a court decree or property settlement will be made only to the spouse or former spouse except where the Board determines that another person shall be recognized to act in behalf of the spouse or former spouse as provided by Part 266 or this chapter, relating to incompetence. Payment will not be made to the heirs, legatees, creditors or assignees of a spouse or former spouse, except that where an amount is payable to a spouse or former spouse pursuant to this part, but is unpaid at the death of that spouse or former spouse, the unpaid amount may be paid in accordance with § 234.1 of this chapter, pertaining to employee annuities unpaid at death.

(e) *Net amount of benefits.* Notwithstanding the terms of the decree or property settlement, the amount of benefits payable to the employee which are subject to this part shall not include:

(1) Amounts deducted to satisfy a debt due the United States, including any amount withheld to recover erroneous payments under the Railroad Retirement Act, Railroad Unemployment Insurance Act, or any other acts administered by the Board, and the amount of any Medicare Part B premium; and

(2) Benefits which are waived pursuant to § 262.6 of this chapter.

(f) *Termination.* Payments to a spouse or former spouse terminate on the earlier of—

(1) The date on which the employee annuity terminates;

(2) The date required by the court decree or property settlement or the law of the jurisdiction in which the court decree or property settlement was entered; or

(3) The last day of the month before the month in which the spouse or former spouse dies.

(g) *Priority.* In the event that the Deputy General Counsel receives more than one decree or property settlement from competing parties, benefits shall be available to satisfy the decrees or property settlements on a first come, first served basis governed by the date of receipt by the Deputy General Counsel. Conflicting decrees or property settlements received on the same day shall be accorded priority based upon the earliest date upon which the decree or property settlement became final.

**§ 295.6 Disclosure of information.**

(a) *Immunity from process.* The provision for the payment of benefits under this part pursuant to a court decree or property settlement shall not be construed to be a waiver of the

sovereign immunity of the Railroad Retirement Board as an agency of the United States Government. The Board may not be joined in a suit for divorce, dissolution, annulment or legal separation, or otherwise subjected to the jurisdiction of any state court. Subpoenas, notices of joinder, interrogatories, orders for production of documents, and like state process issued in connection with a suit for divorce, dissolution, annulment or legal separation will be treated as requests for disclosure of information under this section.

(b) *Request for information.* A response to request for information to be used in connection with a suit for divorce, dissolution, annulment or legal separation may be made by the Deputy General Counsel or his or her designee, by the Associate Executive Director for Retirement Claims, or by a contact representative of the Board's field service.

(c) *Information available.* In the absence of signed authorization from the employee, a spouse or former spouse who is a party to a suit for divorce, dissolution, annulment or legal separation, or his or her legal representative, may be furnished the amount of benefits the employee is currently receiving. If the employee is not currently entitled to benefits, the Board may furnish the amount of any estimated benefit to which the employee would be entitled if he or she were of retirement age at the time of the request, as reflected by the records of the Board, to the extent it is possible for the Board to compute such amount. The Board shall not be required to furnish the present value of future benefits, the amount of benefits payable at a future date, or any other computations based on statistics or procedures not maintained by the Board in the normal course of administration of the Act.

(d) *Certification.* A letter or statement prepared by a Board official in the regular course of duty from the official records of the Board, which refers to the authority of this section and bears his or her signature, shall be a sufficient response for purposes of discharging the repsonsibilities of the Board under this section. A certification in accordance with this section may be considered a public document for purposes of admissibility as evidence of present or potential benefits under the Act for use in a divorce, dissolution, annulment or legal separation proceeding.

**§ 295.7 Miscellaneous.**

(a) *Disbursement cycle.* In honoring and complying with a court decree or property settlement, the Board shall not be required to disrupt its normal disbursement cycle, despite any special schedule of accrual or payment of amounts due the spouse or former spouse set forth in the decree or settlement. A decree or settlement received too late to be honored during the disbursement cycle in which it was received shall be honored with respect to the next payment due the employee.

(b) *Liability for payments.* Neither the Board nor any of its employees shall be liable with respect to any payment made to any individual from moneys due from or payable by the Board pursuant to a court decree or property settlement regular on its face, if such payment is made in accordance with this part.

(c) *Liability for disclosures.* No employee of the Board whose duties include responding to requirements contained in this part shall be subject under any law to any disciplinary action or civil or criminal liability or penalty for, or on account of, any disclosure of information made by such employee in connection with the performance of the employee's duties in making such response.

(d) *Applicable law.* For purposes of a proceeding under this part, the Board will apply the law of the jurisdiction in which the court decree or property settlement was issued unless it comes to the attention of the Board that the state of issuance has no contact with the plaintiff or defendant in the action; in which case, the Board may, in its sole discretion, apply the law of any jurisdiction with significant interest in the matter.

(e) *Erroneous payments.* If a spouse or former spouse receives a payment pursuant to this part from an employee's benefit, and the Board later determines that the employee was not entitled to all or part of those benefits for any month, the amount of the employee's benefits which was paid to the spouse or former spouse in excess of the amount which was actually payable shall be an erroneous payment to the spouse or former spouse within the meaning of section 10 of the Railroad Retirement Act.

Dated: August 23, 1985.

By Authority of the Board.

For the Board.

**Beatrice Ezerski,**

*Secretary to the Board.*

[FR Doc. 85-20947 Filed 8-30-85; 8:45 am]

BILLING CODE 7905-01-M

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Food and Drug Administration

### 21 CFR Part 170

**[Docket No. 84N-0080]**

## Eligibility for Classification of Food Substances as Generally Recognized as Safe; Extension of Comment Period

**AGENCY:** Food and Drug Administration.

**ACTION:** Proposed rule; extension of comment period.

**SUMMARY:** The Food and Drug Administration (FDA) is extending the period for submitting comments on its proposal to amend its regulations to recognize that a substance that was being used in food prior to 1958 can be shwon to be generally recognized as safe (GRAS) through experience based on its common use in food outside, as well as in, the United States. The agency received a request to extend the comment period, and FDA is granting a 60-day extension.

**DATE:** Comments by November 4, 1985.

**ADDRESS:** Written comments to the Dockets Management Branch (HFR-305), Food and Drug Administration, Rm. 4-62, 5600 Fishers Lane, Rockville, MD 20857.

**FOR FURTHER INFORMATION CONTACT:** Gerad L. McCowin, Center for Food Safety and Applied Nutrition (HFF-330), Food and Drug Administration, 200 C St. SW., Washington, DC 20204, 202-472-5676.

**SUPPLEMENTARY INFORMATION:** In the **Federal Register** of July 2, 1985 (50 FR 27294), FDA issued a proposed rule that would amend its regulations to recognize that a substance that was used in food prior to 1958 can be shown to be GRAS through experience based on its common use in food outside, as well as in, the United States. FDA proposed this amendment in response to a court decision that declared invalid an agency regulation that had restricted the experience that could provide the basis for general recognition of safety to experience in the United States. FDA also proposed to delineate the showing that must be made to establish that a substance is FRAS on the basis of its foreign use.

A trade association requested a 60-day extension of the comment period because it needed additional time to obtain views and information from its foreign affiliates on the proposed requirements. The agency believes that extending the comment period an additional 60 days will provide

sufficient time for interested persons to prepare comments on this proposed rule.

Interested persons may, on or before November 4, 1985, submit to the Dockets Management Branch (address above) written comments regarding this proposal. Two copies of any comments are to be submitted, except that individuals may submit one copy. Comments are to be identified with the docket number found in brackets in the heading of this document. Received comments may be seen in the office above between 9 a.m. and 4 p.m., Monday through Friday.

Dated: August 27, 1985.

**Mervin H. Shumate,**

*Acting Associate Commissioner for Regulatory Affairs.*

[FR Doc. 85-20937 Filed 8-30-85; 8:45 am]

BILLING CODE 4160-01-M

## DEPARTMENT OF THE TREASURY

### Internal Revenue Service

### 26 CFR Parts 1 and 602

**[LR-114-85]**

### Information Reporting for Mortgage Credit Certificates

**AGENCY:** Internal Revenue Service, Treasury.

**ACTION:** Notice of proposed rulemaking by cross-reference to temporary regulations.

**SUMMARY:** This document provides proposed regulations that relate to mortgage credit certificates. Changes to the applicable tax law were made by the Tax Reform Act of 1984. These regulations affect all holders and issuers of mortgage credit certificates. In addition, in the Rules and Regulations portion of this Federal Register, the Internal Revenue Service is issuing temporary regulations that relate to mortgage credit certificates. The text of those temporary regulations also serves as the comment document for this proposed rulemaking.

**DATES:** Written comments and requests for a public hearing must be delivered or mailed by November 4, 1985. These regulations are proposed to be effective with respect to mortgage credit certificates issued after September 30, 1985.

**ADDRESS:** Send comments and requests for a public hearing to: Commissioner of Internal Revenue, Attention: CC:LR:T (LR-114-85), Washington, D.C. 20224.

**FOR FURTHER INFORMATION CONTACT:** Mitchell H. Rapaport of the Legislation and Regulations Division, Office of Chief Counsel, Internal Revenue Service, 1111 Constitution Avenue, NW., Washington, D.C. 20224 (Attention: CC:LR:T) (202-566-3740).

**SUPPLEMENTARY INFORMATION:**

#### Background

The temporary regulations in the Rules and Regulations portion of this issue of the **Federal Register** amend § 1.25-4T of Title 26 of the Code of Federal Regulations. The final regulations, which this document proposes to be based on those temporary regulations, would be added to Part 1 of Title 26 of the Code of Fedeal Regulations. For the text of the Temporary Regulations, see FR Doc. 85-20969 (T.D. 8048) published in the Rules and Regulations portion of this issue of the **Federal Register.** The preamble to the temporary regulations explains the addition to the regulations.

On May 8, 1985, temporary and proposed regulations with respect to mortgage credit certificates were published in the **Federal Register** (50 FR 19344; 50 FR 19383). Those regulations reserved § 1.25-4T (e), relating to the information reporting requirement, and § 1.25-4T (f), relating to the policy statement requirment. The Service received numerous written comments responding to a notice of proposed rulemaking published in the **Federal Register** on December 12, 1984 (49 FR 48323), with respect to the reporting and policy statement requirments as they apply to qualified mortgage bonds and qualified veterans' mortgage bonds, and a public hearing was held on April 30, 1985. After consideration of all comments regarding those proposed regulations, temporary and proposed regulations relating to the information reporting and policy statement requirements applicable to mortgage credit certificates are being provided.

The regulations interpret the provisions of section 25(g) of the Code, which add certain information reporting requirements to the requirements that mortgage credit certificate programs must meet.

These regulations are proposed to be issued under the authority of section 25(g) and section 7805 of the Internal Revenue Code (98 Stat. 911, 26 U.S.C. 25(g); 69A State. 917, 26 U.S.C. 7805).

#### Non-Applicability of Executive Order 12291

The Commissioner of Internal Revenue has determined that this proposed rule is not a major rule as defined in Executive Order 12291 and that a regulatory impact analysis therefor is not required.

#### Regulatory Flexibility Analysis

Although this document is a notice of proposed rulemaking that solicits public comment, the Internal Revenue Service has concluded that the regulations proposed herein are interpretative and that the notice and public procedure requirements of 5 U.S.C. 553 do not apply. Accordingly, these proposed regulations do not consititute regulations subject to the Regulatory Flexibility Act (5 U.S.C. chapter 6).

#### Drafting Information

The principal author of these proposed regulations is Mitchell H. Rapaport of the Legislation and Regulations Division of the Office of Chief Counsel, Internal Revenue Service. However, personnel from other offices of the Internal Revenue Service and Treasury Department participated in developing the regulations, on matters of both substance and style.

#### Comments and Requests for a Public Hearing

Before the adoption of these proposed regulations, consideration will be given to any written comments that are submitted (preferably eight copies) to the Commissioner of Internal Revenue. All comments will be available for public inspection and copying. A public hearing will be held upon written request to the Commissioner by any person who has submitted written comments. If a public hearing is held, notice of the time and place will be published in the **Federal Register.** The collection of information requirements contained herein have been submitted to the Office of Management and Budget (OMB) for review under section 3504(h) of the Paperwork Reduction Act. Comments on the requirements should be sent to the Office of Information and Regulatory Affairs, of OMB, Attention: Desk Officer for Internal Revenue Service, New Executive Office Building, Washigton, D.C. 20503. The Internal Revenue Service requests persons submitting comments to OMB also to send copies of the comments to the Service.

**James I. Owens,**

*Acting Commissioner of Internal Revenue.*

[FR Doc. 85-20970 Filed 8-29-85; 10:54 am]

BILLING CODE 4830-01-M

## DEPARTMENT OF THE INTERIOR

### Office of Surface Mining Reclamation and Enforcement

### 30 CFR Part 817

### Permanent Program Performance Standards; Underground Activities, Subsidence Control

**AGENCY:** Office of Surface Mining Reclamation and Enforcement, Interior.

**ACTION:** Notice of Public Hearing.

**SUMMARY:** On July 8, 1985, the Office of Surface Mining Reclamation and Enforcement (OSM) of the U.S. Department of the Interior (DOI) proposed to revise portions of its subsidence control rules relating to the protection of surface structures and facilities.

In response to a request from interested citizens a public hearing on the proposed subsidence control rules revisions is hereby scheduled at the location and time given below.

**DATE:** September 12, 1985, 7:00 p.m. to 10:00 p.m.

**ADDRESS:** Student Center, Rend Lake Junior College, Route 1, Ina, Illinois 62846.

**FOR FURTHER INFORMATION CONTACT:** Dr. C.Y. Chen, Office of Surface Mining, U.S. Department of the Interior, 1951 Constitution Avenue, NW., Washington, D.C. 20240; Telephone 202/343-1501 (Commercial or FTS).

**SUPPLEMENTARY INFORMATION:**

I. Public Hearing
II. Background

#### I. Public Hearing

The public hearing will continue until all persons wishing to testify have been heard. To assist the transcriber and ensure an accurate record, OSM requests that persons who testify at the hearing give the transcriber a written copy of their testimony. OSM also requests that persons who plan to testify submit to OSM an advance copy of their testimony at the following address: Office of Surface Mining, Administrative Record, Room 5124B-L, 1951 Constitution Avenue, N.W., Washington, D.C. 20240.

#### II. Background

The Office of Surface Mining Reclamation and Enforcement (OSM), pursuant to the Court's order in *In Re: Permanent Surface Mining Regulation Litigation (II)*, No. 79-1144 (D.D.C.) (Memorandum Opinion filed Oct. 1, 1984), has proposed to revise portions of its subsidence control rules. (50 FR 27910, July 8, 1985).

The Court remanded to the Secretary for proper notice and comment the 1983 final rule, 30 CFR 817.121(c)(2) (48 FR 24652) which requires operators to redress subsidence-caused material damage to structures only to the extent required by State law. In addition to remanding § 817.121(c)(2) of the 1983 rule on Administrative Procedure Act grounds, the Court ordered OSM to request comments on the deletion of the subsidence monitoring requirement of 30 CFR 784.20(d), 44 FR 14902 (March 13, 1979), from the 1983 final rule.

A detailed discussion of these issues is set forth in the preamble to the proposed rule (50 FR 27910 July 8, 1985).

Dated: August 27, 1985.

**H. Leonard Richeson,**

*Acting Assistant Director, Technical Service and Research.*

[FR Doc. 85-20910 Filed 8-30-85; 8:45 am]

BILLING CODE 4310-05-M

## DEPARTMENT OF DEFENSE

### Corps of Engineers, Department of the Army

### 33 CFR Part 207

### Naval Restricted Area in the Pacific Ocean at San Clemente Island, CA

**AGENCY:** U.S. Army Corps of Engineers, DoD.

**ACTION:** Notice of proposed rulemaking.

**SUMMARY:** The U.S. Navy has requested the Corps of Engineers to establish a naval restricted area in the Pacific Ocean at San Clemente Island, California, in the vicinity of West Cove. If established, the restricted area will prohibit vessels from anchoring in that designated area for the protection of the Navy's submarine cables.

**DATE:** Comments must be submitted on or before October 3, 1985.

**ADDRESS:** HQDA, DAEN-CWO-N, Washington, D.C. 20314-1000.

**FOR FURTHER INFORMATION CONTACT:** Mr. Glenn Lukos at (213) 894-5606 or Mr. Ralph T. Eppard at (202) 272-0199.

**SUPPLEMENTARY INFORMATION:** The Corps of Engineers proposes to establish a restricted area in the vicinity of West Cove, San Clemente, California. This proposed restricted area would not affect normal vessel traffic in the area except with regard to a prohibition on anchoring. A drawing showing the configuration of the restricted area is available from the Los Angeles District Engineer by calling the local number listed under "**FOR FURTHER INFORMATION CONTACT.**"

Note.—This proposed regulation is issued with respect to a military function of the Defense Department, is not a major rule within the meaning of Executive Order 12291, and accordingly, the provisions of Executive Order 12291 do not apply. The Corps of Engineers also certifies that this regulation would not have a significant economic impact on a substantial number of entities and thus does not require preparation of regulatory flexibility analysis.

**List of Subjects in 33 CFR Part 207**

Navigation, Navigation (Water), Water transportation, Waterways.

Accordingly, 33 CFR Part 207 is amended as follows:

### PART 207—NAVIGATION REGULATIONS

1. The authority for Part 207 continues to read as follows:

Authority: 40 Stat. 266; 33 U.S.C. 1

2. Section 207.614a is added to read as follows:

**§ 207.614a Pacific Ocean at San Clemente, Cal.; naval restricted area.**

(a) *The Area.* All waters between the northern and southern boundaries of the area known as West Cove seaward approximately four miles.

The northern boundary is defined by the coordinates:

118°36'18" W 33°00'52" N
118°37'30" W 32°59'30" N
118°38'38" W 32°59'20" N

The southern boundary is defined by the coordinates:

118°35'27" W 33°00'40" N
118°36'40" W 32°58'30" N
118°38'38" W 32°57'45" N

(b) *The Regulation.* (1) The use of this area for anchorage is prohibited to all craft at all times.

(2) The regulations in this section shall be enforced by the Commander, Naval Base, San Diego, and such agencies as he/she shall designate.

Dated: August 15, 1985.

**Dennis J. York,**

*Colonel, Corps of Engineers, Executive Director of Civil Works.*

[FR Doc. 85-20955 Filed 8-30-85; 8:45 am]

BILLING CODE 3710-08-M

## ENVIRONMENTAL PROTECTION AGENCY

### 40 CFR Part 147

[OW-FRL-2890-2]

### Underground Injection of Hazardous Waste

**AGENCY:** Environmental Protection Agency.

**ACTION:** Notice of Technical Seminar.

**SUMMARY:** The purpose of this notice is to announce that the Environmental Protection Agency (EPA) will hold a technical seminar concerning EPA's activities in the underground injection of hazardous wastes.

The seminar will provide EPA additional information and public opinion necessary to design EPA's technical effort in this area.

**DATES:** The technical seminar will be held on September 26, 1985, from 8:30 a.m. to 5:00 p.m. Requests to present oral presentations should be filed by August 30, 1985. If sufficient public interest in holding the seminar is not expressed by September 6, 1985, EPA reserves the right to cancel the seminar pursuant to the provisions of 40 CFR 145.31(c). If the seminar is cancelled, those persons having expressed interest in attending the seminar will be notified of the cancellation. Written comments can be made regardless of whether or not a seminar is held.

**ADDRESSES:** Comments and requests to make a formal presentation should be mailed to Joyce Kelly, State Programs Division, Environmental Protection Agency, 401 M St., SW., Washington, DC 20460.

The seminar will be held in the Virginian Hotel, 1500 Arlington Boulevard, Arlington, Virginia 22209.

**FOR FURTHER INFORMATION CONTACT:** Joyce Kelly, State Programs Division, Environmental Protection Agency, 401 M St., SW., Washington, DC 20460, (202) 382-5522.

**SUPPLEMENTARY INFORMATION:**

Subsection 3004(f) of the Resource Conservation and Recovery Act (RCRA), as amended, (42 U.S.C. 6924(f)) requires that the Administrator make a determination regarding the disposal of certain hazardous wastes by underground injection into deep wells. If it may reasonably be determined that such disposal may not be protective of human health and the environment for as long as the wastes remain hazardous, the disposal of these wastes into deep injection wells will be banned. The purpose of this meeting is to discuss the technical aspects of such disposal and to obtain information from the interested public regarding the effects of a possible ban.

Authority: Secs. 1421 and 1422, Pub. L. 93-523, 88 Stat. 1674 as amended (300 U.S.C. 300h, 300h-1).

Dated: August 23, 1985.

**Henry Longest II,**

*Acting Assistant Administrator for Water.*

[FR Doc. 85-20943 Filed 8-30-85; 8:45 am]

BILLING CODE 6560-50-M

## FEDERAL COMMUNICATIONS COMMISSION

### 47 CFR Part 73

[MM Docket No. 85-256; RM-4924]

### FM Broadcast Station In Hoxie, AR

**AGENCY:** Federal Communications Commission.

**ACTION:** Proposed Rule.

**SUMMARY:** Action taken herein proposes to allot FM Channel 263A to Hoxie, Arkansas, as that community's first local service, in response to a petition filed by Dennis Mitchell.

**DATES:** Comments must be filed on or before October 21, 1985, and reply comments on or before November 5, 1985.

**ADDRESS:** Federal Communications Commission, Washington, D.C. 20554.

**FOR FURTHER INFORMATION CONTACT:** Nancy V. Joyner, Mass Media Bureau, (202) 634-6530.

**SUPPLEMENTARY INFORMATION:**

**List of Subjects in 47 CFR Part 73**

Radio broadcasting.

The authority citation for Part 73 continues to read:

Authority: Secs. 4 and 303, 48 Stat. 1066, as amended, 1082, as amended; 47 U.S.C. 154, 303. Interpret or apply secs. 301, 303, 307, 48 Stat. 1081, 1082, as amended, 1083, as amended, 47 U.S.C. 301, 303, 307. Other statutory and executive order provisions authorizing or interpreted or applied by specific sections are cited to text.

### Notice of Proposed Rulemaking

In the matter of amendment of § 73.202(b), table of allotments, FM broadcast stations (Hoxie, Arkansas); MM Docket No. 85-256, RM-4924.

Adopted: August 13, 1985.

Released: August 28, 1985.

By the Chief, Policy and Rules Division.

1. Before the Commission for consideration is a petition for rule making filed by Dennis Mitchell ("petitioner") requesting the allocation of FM Channel 263A to Hoxie, Arkansas, as that community's first local service. Petitioner indicates that he will apply for the channel, if allocated.

2. A staff engineering analysis reveals that Channel 263A can be allotted to Hoxie in conformity with the minimum distance separation requirements of § 73.207 of the Commission's Rules.

### PART 73—[AMENDED]

**§ 73.202 [Amended]**

3. Since the proposed allotment could provide a first local service to Hoxie, Arkansas, the Commission believes it is appropriate to propose amending the FM Table of Allotments, § 73.202(b) of the Commission's Rules, to include that community, as follows:

| City | Channel No. | |
|---|---|---|
| | Present | Proposed |
| Hoxie, AR | | 263A |

4. The Commission's authority to institute rule making proceedings, showings required, cut-off procedures, and filing requirements are contained in the attached Appendix and are incorporated by reference herein.

Note: A showing of continuing interest is required by paragraph 2 of the Appendix before a channel will be allotted.

5. Interested parties may file comments on or before October 21, 1985, and reply comments on or before November 5, 1985, and are advised to read the Appendix for the proper procedures. Additionally, a copy of such comments should be served on the petitioners, or their counsel or consultant, as follows: Dan Winn & Associates, 500 East Markham Street, P.O. Box 214, Little Rock, AR 72203 (Consultant to Petitioner).

6. The Commission has determined that the relevant provisions of the Regulatory Flexibility Act of 1980 do not apply to rule making proceedings to amend the FM Table of Allotments, § 73.202(b) of the Commission's Rules. See, *Certification that sections 603 and 604 of the Regulatory Flexibility Act Do Not Apply to Rule Making to Amend §§ 73.202(b), 73.504 and 73.606(b) of the Commission's Rules*, 46 FR 11549, published February 9, 1981.

7. For further information concerning this proceeding, contact Nancy V. Joyner, Mass Media Bureau, (202) 634-6530. However, members of the public should note that from the time a Notice of Proposed Rule Making is issued until the matter is no longer subject to Commission consideration or court review, all *ex parte* contacts are prohibited in Commission proceedings.

such as this one, which involve channel allotments. An *ex parte* contact is a message (spoken or written) concerning the merits of a pending rule making, other than comments officially filed at the Commission, or oral presentation required by the Commission. Any comment which has not been served on the petitioner constitutes an *ex parte* presentation and shall not be considered in the proceeding. Any reply comment which has not been served on the person(s) who filed the comment, to which the reply is directed, constitutes an *ex parte* presentation and shall not be considered in the proceeding.

Federal Communications Commission.

**Charles Schott,**

*Chief, Policy and Rules Division, Mass Media Bureau.*

### Appendix

1. Pursuant to authority found in sections 4(i), 5(d)(1), 303 (g) and (r), and 307(b) of the Communications Act of 1934, as amended, and §§ 0.61, 0.204(b) and 0.283 of the Commission's Rules, it is proposed to amend the FM Table of Allotments, § 73.202(b) of the Commission's Rules and Regulations, as set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached.

2. *Showings Required.* Comments are invited on the proposal(s) discussed in the *Notice of Proposed Rule Making* to which this Appendix is attached. Proponent(s) will be expected to answer whatever questions are presented in initial comments. The proponent of a proposed allotment is also expected to file comments even if it only resubmits or incorporates by reference its former pleadings. It should also restate its present intention to apply for the channel if it is allotted and, if authorized, to build a station promptly. Failure to file may lead to denial of the request.

3. *Cut-off Procedures.* The following procedures will govern the consideration of filings in this proceeding.

(a) Counterproposals advanced in this proceeding itself will be considered, if advanced in initial comments, so that parties may comment on them in reply comments. They will not be considered if advanced in reply comments. (See § 1.420(d) of the Commission's Rules.)

(b) With respect to petitions for rule making which conflict with the proposal(s) in this *Notice*, they will be considered as comments in the proceeding, and Public Notice to this effect will be given as long as they are filed before the date for initial comments herein. If they are filed later than that, they will not be considered in connection with the decision in this docket.

(c) The filing of a counterproposal may lead the Commission to allot a different channel than was requested for any of the communities involved.

4. *Comments and Reply Comments; Service.* Pursuant to applicable procedures set out in §§ 1.415 and 1.420 of the Commission's Rules and Regulations, interested parties may file comments and reply comments on or before the dates set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached. All submissions by parties to this proceeding or persons acting on behalf of such parties must be made in written comments, reply comments, or other appropriate pleadings. Comments shall be served on the petitioner by the person filing the comments. Reply comments shall be served on the person(s) who filed comments to which the reply is directed. Such comments and reply comments shall be accompanied by a certificate of service. (See §§ 1.420 (a), (b) and (c) of the Commission's Rules.)

5. *Number of Copies.* In accordance with the provisions of § 1.420 of the Commission's Rules and Regulations, an original and four copies of all comments, reply comments, pleadings, briefs, or other documents shall be furnished the Commission.

6. *Public Inspection of Filings.* All filings made in this proceeding will be available for examination by interested parties during regular business hours in the Commission's Public Reference Room at its headquarters, 1919 M Street NW., Washington, D.C.

[FR Doc. 85-20884 Filed 8-30-85; 8:45 am]

BILLING CODE 6712-01-M

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## 47 CFR Part 73

**[MM Docket No. 85-257; RM-4913]**

## FM Broadcast Station in Hemet, CA

**AGENCY:** Federal Communications Commission.

**ACTION:** Proposed rule.

**SUMMARY:** Action taken herein proposes the substitution of Channel 289A for Channel 288A at Hemet, California, and modification of the license of Station KHYE (FM), in response to a petition filed by the 2588 Newport Corporation.

**DATES:** Comments must be filed on or before October 21, 1985, and reply comments on or before November 5, 1985.

**ADDRESS:** Federal Communications Commission, Washington, D.C. 20554.

**FOR FURTHER INFORMATION CONTACT:** Nancy V. Joyner, Mass Media Bureau, (202) 634-6530.

**SUPPLEMENTARY INFORMATION:**

### List of Subjects in 47 CFR Part 73

Radio broadcasting.

The authority citation for Part 73 continues to read:

Authority: Secs. 4 and 303, 48 Stat. 1066, as amended, 1082, as amended; 47 U.S.C. 154, 303. Interpret or apply secs. 301, 303, 307, 48 Stat. 1081, 1082, as amended, 1063, as amended, 47 U.S.C. 301, 303, 307. Other statutory and executive order provisions authorizing or interpreted or applied by specific sections are cited to text.

### Notice of Proposed Rule Making

In the matter of amendment of § 73.202(b), table of allotments FM broadcast stations (Hemet, California); MM Docket No. 85-257, RM-4913.

Adopted: August 13, 1985.

Released: August 28, 1985.

By the Chief, Policy and Rules Division.

1. Before the Commission for consideration is a petition for rule making filed by the 2588 Newport Corporation, licensee of Station KHYE(FM) (Channel 288A), Hemet, California, requesting the substitution of Channel 289A for 288A at Hemet, and modification of its license to specify operation on Channel 289A.

2. Petitioner's request is premised on its desire to relocate its transmitter to a higher elevation to afford maximum utilization of the channel, thereby enabling it to more fully serve Hemet's growing population. In support of its request, petitioner advises that it is severely restricted from fully utilizing the facilities of Station KHYE(FM) at its present site due to constraints imposed by co-channel and adjacent channel stations to the east, west and south. As a result of technical limitations, Station KHYE(FM) now operates with an antenna at −75 meters, which is notably below the maximum of 100 meters provided for by our Rules. Petitioner claims the proposed channel substitution would enable it to move southeast of Hemet to Polly Butte mountain, from which maximum coverage of Hemet could be attained.

3. We believe the petitioner's proposal warrants consideration. The channel can be substituted in compliance with the minimum distance separation requirements of § 73.207(b) of the Commission's Rules. Also, we shall propose to modify the license of Station KHYE(FM) (Channel 288A) to specify operation on Channel 289A.

## PART 73—[AMENDED]

### § 73.202 [Amended]

4. In view of the fact that the requested substitution of channels could provide Hemet with expanded coverage, the Commission believes it is appropriate to propose amending the FM Table of Allotments, § 73.202(b) of the Commission's Rules, as follows:

| City | Channel No. | |
|---|---|---|
| | Present | Proposed |
| Hemet, CA | 267A, 288A | 267A, 289A |

5. Since Hemet is located within 320 kilometers (199 miles) of the common U.S.-Mexican border, concurrence of the Mexican Government must be obtained.

6. The Commission's authority to institute rule making proceedings, showings required, cut-off procedures, and filing requirements are contained in the attached Appendix and are incorporated by reference herein.

Note: A showing of continuing interest is required by paragraph 2 of the Appendix before a channel will be allotted.

7. Interested parties may file comments on or before October 21, 1985, and reply comments on or before November 5, 1985, and are advised to read the Appendix for the proper procedures. Additionally, a copy of such comments should be served on the petitioners, or their counsel or consultant, as follows: Richard S. Rodin, Esq., Hogan and Hartson, 815 Connecticut Avenue NW., Washington, D.C. 20006–4072, (Counsel for Petitioner).

8. The Commission has determined that the relevant provisions of the Regulatory Flexibility Act of 1980 do not apply to rule making proceedings to amend the FM Table of Allotments, § 73.202(b) of the Commission's Rules. See, *Certification that sections 603 and 604 of the Regulatory Flexibility Act Do Not Apply to Rule Making to Amend §§ 73.202(b) 73.504 and 73.606(b) of the Commission's Rules*, 46 FR 11549, published February 9, 1981.

9. For further information concerning this proceeding, contact Nancy V. Joyner, Mass Media Bureau, (202) 634–6530. However, members of the public should note that from the time a Notice of Proposed Rule Making is issued until the matter is no longer subject to Commission consideration or court review, all *ex parte* contacts are prohibited in Commission proceedings, such as this one, which involve channel allotments. An *ex parte* contact is a message (spoken or written) concerning the merits of a pending rule making, other than comments officially filed at the Commission, or oral presentation required by the Commission. Any comment which has not been served on the petitioner costitutes an *ex parte* presentation and shall not be considered in the proceeding. Any reply comment which has not been served on the person(s) who filed the comment, to which the reply is directed, constitutes an *ex parte* presentation and shall not be considered in the proceeding.

Federal Communications Commission.

**Charles Schott,**

*Chief, Policy and Rules Division, Mass Media Bureau.*

### Appendix

1. Pursuant to authority found in sections 4(i), 5(d)(1), 303 (g) and (r), and 307(b) of the Communications Act of 1934 as amended, and § 0.61, 0.204(b) and 0.283 of the Commission's Rules, it is proposed to amend the FM Table of Allotments, § 73.202(b) of the Commission's Rules and Regulations, as set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached.

2. *Showings Required.* Comments are invited on the proposal(s) discussed in the *Notice of Proposed Rule Making* to which this Appendix is attached. Proponent(s) will be expected to answer whatever questions are presented in initial comments. The proponent of a proposed allotment is also expected to file comments even if it only resubmits or incorporates by reference its former pleadings. It should also restate its present intention to apply for the channel if it is allotted and, if authorized, to build a station promptly. Failure to file may lead to denial of the request.

3. *Cut-off Procedures.* The following procedures will govern the consideration, of filings in this proceeding.

(a) Counterproposals advanced in this proceeding itself will be considered, if advanced in initial comments, so that parties may comment on them in reply comments. They will not be considered if advanced in reply comments. (See § 1.420(d) of the Commission's Rules.)

(b) With respect to petitions for rule making which conflict with the proposal(s) in this *Notice*, they will be considered as comments in the proceeding, and Public Notice to this effect will be given as long as they are filed before the date for filing initial comments herein. If they are filed later than that, they will not be considered in connection with the decision in this docket.

(c) The filing of a counterproposal may lead the Commission to allot a different channel than was requested for any of the communities involved.

4. *Comments and Reply Comments; Service.* Pursuant to applicable procedures set out in §1.415 and 1.420 of the Commission's Rules and Regulations, interested parties may file comments and reply comments on or before the dates set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached. All submissions by parties to this proceeding or persons acting on behalf of such parties must be made in written comments, reply comments, or other appropriate pleadings. Comments shall be served on the petitioner by the person filing the comments. Reply comments shall be served on the person(s) who filed comments to which the reply is directed. Such comments and reply comments shall be accompanied by a certificate of service. (See § 1.420 (a), (b) and (c) of the Commission's Rules.)

5. *Number of Copies.* In accordance with the provisions of § 1.420 of the Commission's Rules and Regulations, an original and four copies of all comments, reply comments, pleadings, briefs, or other documents shall be furnished the Commission.

6. *Public Inspection of Filings.* All filings made in this proceeding will be available for examination by interested parties during regular business hours in the Commission's Public Reference Room at its headquarters, 1919 M Street NW., Washington, D.C.

[FR Doc. 85–20885 Filed 8–30–85; 8:45 am]
BILLING CODE 6712–01–M

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**47 CFR Part 73**

**[MM Docket No. 85-262; RM-4922]**

## FM Broadcast Station in King City, CA

**AGENCY:** Federal Communications Commission.

**ACTION:** Proposed rule.

**SUMMARY:** Action taken herein proposes the substitution of Class B1 FM Channel 230 for Channel 221A at King City, California, and modification of the Class A license for Station KLFA(FM), in response to a petition filed by Ralin Broadcasting Corporation. The proposed allotment could provide King City with its first wide-coverage Class B1 FM station.

**DATES:** Comments must be filed on or before October 18, 1985, and reply comments on or before November 4, 1985.

**ADDRESS:** Federal Communications Commission, Washington, D.C. 20554.

**FOR FURTHER INFORMATION CONTACT:**
Nancy V. Joyner, Mass Media Bureau, (202) 634–6530.

**SUPPLEMENTARY INFORMATION:**

**List of Subjects in 47 CFR Part 73**

Radio broadcasting.

The authority citation for Part 73 continues to read:

Authority: Secs. 4 and 303, 48 Stat. 1066, as amended, 1082, as amended; 47 U.S.C. 154, 303. Interpret or apply secs. 301, 303, 307, 48 Stat. 1081, 1082, as amended, 1083, as amended, 47 U.S.C. 301, 303, 307. Other statutory and executive order provisions authorizing or interpreted or applied by specific sections are cited to text.

**Proposed Rule Making**

In the matter of amendment of § 73.202(b), table of allotments, FM broadcast stations (King City, California); MM Docket No. 85–262, RM–4922.

Adopted: August 13, 1985.
Released: August 27, 1985.

By the Chief, Policy and Rules Division.

1. Before the Commission for consideration is a petition for rule making filed by Ralin Broadcasting Corporation ("petitioner"), licensee of FM Station KLFA(FM) (Channel 221A), King City, California, which seeks to substitute Channel 230B1 for Channel 221A and modify its license to specify operation on the Class B1 channel.

2. In justification of its proposal, petitioner states that a modification to the Class B1 channel would enable it to provide expanded coverage, and thus improve service to its audience.

3. We believe the proposal warrants consideration in view of the expressed desire for a wider coverage area FM station to serve the public interest. A staff engineering study reveals that the proposed allotment of Channel 230B1 can be made at the present site of Station KLFA(FM) consistent with the minimum distance separation requirements of § 73.207(b) of the Commission's Rules.

4. Mindful of the Commission's modification policy, as expressed in *Cheyenne, Wyoming*, 62 F.C.C. 2d 63 (1976), petitioner advises that should another interest in the proposed allotment be shown, there are several other Class B1 channels available to King City to accommodate such interest. See, *Modification of FM and TV Station Licenses*, 56 R.R. 2d 1253 (1984). Specifically, petitioner advises that Channel 238B1 can be allotted to King City with a site restriction approximately 8 miles southwest of the Community.

**PART 73—[AMENDED]**

**§ 73.202 [Amended]**

5. Accordingly, we consider it appropriate to seek comments on the proposal to amend the FM Table of Allotments, § 73.202(b) of the Commission's Rules, as follows:

| City | Channel No. | |
|---|---|---|
| | Present | Proposed |
| King City, California | 221A | 230B1 |

6. The Commission's authority to institute rule making proceedings, showings required, cut-off procedures, and filing requirements are contained in the attached Appendix and are incorporated by reference herein.

**Note.**—A showing of continuing interest is required by paragraph 2 of the Appendix before a channel will be allotted.

7. Interested parties may file comments on or before October 18, 1985, and reply comments on or before November 4, 1985, and are advised to read the Appendix for the proper procedures. Additionally, a copy of such comments should be served on the petitioners, or their counsel or consultant, as follows: Vincent J. Curtis, Jr., Esq., Dan J. Alpert, Esq., Fletcher, Heald and Hildreth, 1225 Connecticut Avenue, NW., Washington, D.C. 20036 (Counsel for Petitioner).

8. The Commission had determined that the relevant provisions of the Regulatory Flexibility Act of 1980 do not apply to rule making proceedings to amend the FM Table of Allotments, § 73.202(b) of the Commission's Rules. See, *Certification that sections 603 and 604 of the Regulatory Flexibility Act Do Not Apply to Rule Making to Amend §§ 73.202(b), 73.504 and 73.606(b) of the Commission's Rules*, 46 FR 11549, published February 9, 1981.

9. For further information concerning this proceeding, contact Nacy V. Joyner, Mass Media Bureau, (202) 634–6530. However, members of the public should note that from the time a Notice of Proposed Rule Making is issued until the matter is no longer subject to Commission consideration or court review, all *ex parte* contacts are prohibited in Commission proceedings, such as this one, which involve channel allotments. An *ex parte* contact is a message (spoken or written) concerning the merits of a pending rule making, other than comments officially filed at the Commission, or oral presentation required by the Commission. Any comment which has not been served on the petitioner constitutes an *ex parte* presentation and shall not be considered in the proceeding. Any reply comment which has not been served on the person(s) who filed the comment, to which the reply is directed, constitutes an *ex parte* presentation and shall not be considered in the proceeding.

Federal Communications Commission.

**Charles Schott,**

*Chief, Policy and Rules Division, Mass Media Bureau.*

**Appendix**

1. Pursuant to authority found in sections 4(i), 5(d)(1), 303 (g) and (r), and 307(b) of the Communications Act of 1934, as amended, and §§ 0.61, 0.204(b) and 0.283 of the Commission's Rules, it is proposed to amend the FM Table of Allotments, § 73.202(b) of the Commission's Rules and Regulations, as set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached.

2. *Showings Required.* Comments are invited on the proposal(s) discussed in the *Notice of Proposed Rule Making* to which this Appendix is attached. Proponent(s) will be expected to answer whatever questions are presented in initial comments. The proponent of a proposed allotment is also expected to file comments even if it only resubmits or incorporates by reference its former pleadings. It should also restate its present intention to apply for the channel if it is allotted and, if authorized, to build a station promptly. Failure to file may lead to denial of the request.

3. *Cut-off Procedures.* The following procedures will govern the consideration of filings in this proceeding.

(a) Counterproposals advanced in this proceeding itself will be considered, if advanced in inital comments, so that parties may comment on them in reply comments. They will not be considered if advanced in reply comments. (See *§ 1.420(d) of the Commission's Rules.)*

(b) With respect to petitions for rule making which conflict with the proposal(s) in this *Notice*, they will be considered as comments in the proceeding, and Public Notice to this effect will be given as long as they are filed before the date for filing initial comments herein. If they are filed later than that, they will not be considered in connection with the decision in this docket.

(c) The filing of a counterproposal may lead the Commission to allot a different channel than was requested for any of the communities involved.

4. *Comments and Reply Comments; Service.* Pursuant to applicable

procedures set out in §§ 1.415 and 1.420 of the Commission's Rules and Regulations, interested parties may file comments and reply comments on or before the dates set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached. All submissions by parties to this proceeding or persons acting on behalf of such parties must be made in written comments, reply comments, or other appropriate pleadings. Comments shall be served on the petitioner by the person filing the comments. Reply comments shall be served on the person(s) who filed comments to which the reply is directed. Such comments and reply comments shall be accompanied by a certificate of service. (See § 1.420 (a), (b) and (c) of the Commission's Rules.)

5. *Number of Copies.* In accordance with the provisions of § 1.420 of the Commission's Rules and Regulations, an original and four copies of all comments, reply comments, pleadings, briefs, or other documents shall be furnished the Commission.

6. *Public Inspection of Filings.* All filings made in this proceeding will be available for examination by interested parties during regular business hours in the Commission's Public Reference Room at its headquarters, 1919 M Street, NW., Washington, D.C.

[FR Doc. 85-20886 Filed 8-30-85; 8:45 am]
BILLING CODE 6712-01-M

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## 47 CFR Part 73

**[MM Docket No. 85-261; RM-4951]**

## FM Broadcast Station in Paauilo, HI

**AGENCY:** Federal Communications Commission.

**ACTION:** Proposed rule.

**SUMMARY:** This action proposes the substitution of Class C Channel 279 for Channel 240A at Paauilo, Hawaii, and modification of the Class A license for Station KCHR(FM) accordingly, in response to a petition filed by Hamakua Broadcasting Corporation.

**DATES:** Comments must be filed on or before October 18, 1985, and reply comments on or before November 4, 1985.

**ADDRESS:** Federal Communications Commission, Washington, D.C. 20554.

**FOR FURTHER INFORMATION CONTACT:** Montrose H. Tyree, Mass Media Bureau, (202) 634-6530.

**SUPPLEMENTARY INFORMATION:**

**List of Subjects in 47 CFR Part 73**

Radio broadcasting.

The authority citation for Part 73 continues to read:

Authority: Secs. 4 and 303, 48 Stat. 1066, as amended, 1082, as amended; 47 U.S.C. 154, 303. Interpret or apply secs. 301, 303, 307, 48 Stat. 1081, 1082, as amended, 1083, as amended, 47 U.S.C. 301, 303, 307. Other statutory and executive order provisions authorizing or interpreted or applied by specific sections are cited to text.

### Notice of Proposed Rule Making

In the matter of amendment of § 73.202(b), table of allotments, FM broadcast stations (Paauilo, Hawaii); MM Docket No. 85-261, RM-4951.

Adopted: August 13, 1985.
Released: August 27, 1985.

By the Chief, Policy and Rules Division.

1. The Commission herein considers a petition for rule making filed by Hamakua Broadcasting Corporation ("Hamakua") ("petitioner"), licensee of Station KHCR(FM), Paauilo, Hawaii, which seeks to substitute Channel 279 for Channel 240A at Paauilo, and to modify its license to specify operation on the Class C channel.

2. In support of the proposal, Hamakua states that the northern part of the Island of Hawaii is severely under-served by local programming. Consequently, it intends to provide a first source of locally oriented programming as well as civic information and news to the region.

3. In accordance with our established policy, we shall propose to modify the license of Station KHCR(FM) to specify operation on Channel 279. Pursuant to the Commission's Rules, § 1.420(g), the modification cannot be implemented if another party expresses an interest in the proposed allotment unless an additional equivalent channel is available for allotment to Paauilo. See *Modification of FM Station Licenses*, 98 F.C.C. 2d 916 (1984).

### PART 73—[AMENDED]

**§ 73.202 [Amended]**

4. In view of the need for a wide coverage area FM station, the Commission proposes to amend the FM Table of Allotments, § 73.202(b) of the Rules, as it pertains to Paauilo, Hawaii as follows:

| City | Channel No. | |
|---|---|---|
| | Present | Proposed |
| Paauilo, Hawaii | 240A | 279 |

5. The Commission's authority to institute rule making proceedings, showings required, cut-off procedures, and filing requirements are contained in the attached Appendix and are incorporated by reference herein.

**Note:** A showing of continuing interest is required by paragraph 2 of the Appendix before a channel will be allotted.

6. Interested parties may file comments on or before October 18, 1985, and reply comments on or before November 4, 1985, and are advised to read the Appendix for the proper procedures. Additionally, a copy of such comments should be served on the petitioners, or their counsel or consultant, as follows: F. Joseph Brinig, 1200—29th Street NW., Washington, D.C. 20007 (Counsel to Hamakua)

7. The Commission has determined that the relevant provisions of the Regulatory Flexibility Act of 1980 do not apply to rule making proceedings to amend the FM Table of Allotments § 73.202(b) of the Commission's Rules. See, *Certification that sections 603 and 604 of the Regulatory Flexibility Act Do Not Apply to Rule Making to Amend §§ 73.202(b), 73.504 and 73.606(b) of the Commission's Rules*, 46 FR 11549, published February 9, 1981.

8. For further information concerning this proceeding, contact Montrose H. Tyree, Mass Media Bureau, (202) 634-6530. However, members of the public should note that from the time a Notice of Proposed Rule Making is issued until the matter is no longer subject to Commission consideration or court review, all *ex parte* contacts are prohibited in Commission proceedings, such as this one, which involve channel allotments. An *ex parte* contact is a message (spoken or written) concerning the merits of a pending rule making, other than comments officially filed at the Commission, or oral presentation required by the Commission. Any comment which has not been served on the petitioner constitutes an *ex parte* presentation and shall not be considered in the proceeding. Any reply comment which has not been served on the person(s) who filed the comment, to which the reply is directed, constitutes an *ex parte* presentation and shall not be considered in the proceeding.

Federal Communications Commission.

**Charles Schott,**

*Chief, Policy and Rules Division, Mass Media Bureau.*

### Appendix

1. Pursuant to authority found in sections 4(i), 5(d)(1), 303(g) and (r), and 307(b) of the Communications Act of 1934, as amended, and §§ 0.61, 0.204(b) and 0.283 of the Commission's Rules. It is proposed to amend the FM Table of Allotments, § 73.202(b) of the

Commission's Rules and Regulations, as set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached.

2. *Showings Required.* Comments are invited on the proposal(s) discussed in the *Notice of Proposed Rule Making* to which this Appendix is attached. Proponent(s) will be expected to answer whatever questions are presented in initial comments. The proponent of a proposed allotment is also expected to file comments even if it only resubmits or incorporated by reference its former pleadings. It should also restate its present intention to apply for the channel if it is allotted and, if authorized, to build a station promptly. Failure to file may lead to denial of the request.

3. *Cut-off Procedures.* The following procedures will govern the consideration of filings in this proceeding.

(a) Counterproposals advanced in this proceeding itself will be considered, if advanced in initial comments, so that parties may comment on them in reply comments. They will not be considered if advanced in reply comments. (See § 1.420(d) of the Commission's Rules.)

(b) With respect to petitions for rule making which conflict with the proposal(s) in this *Notice*, they will be considered as comments in the proceeding, and Public Notice to this effect will be given as long as they are filed before the date for filing initial comments herein. If they are filed later than that, they will be considered in connection with the decision in this docket.

(c) The filing of a counterproposal may lead the Commission to allot a different channel than was requested for any of the communities involved.

4. *Comments and Reply Comments; Service.* Pursuant to applicable procedures set out in §§ 1.415 and 1.420 of the Commission's Rules and Regulations, interested parties may file comments and reply comments on or before the dates set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached. All submissions by parties to this proceeding or persons acting on behalf of such parties must be made in written comments, reply comments, or other appropriate pleadings. Comments shall be served on the petitioner by the person filing the comments. Reply comments shall be served on the person(s) who filed comments to which the reply is directed. Such comments and reply comments shall be accompanied by a certificate of service. (See § 1.420(a), (b) and (c) of the Commission's Rules.)

5. *Number of Copies.* In accordance with the provisions of § 1.420 of the Commission's Rules and Regulations, an original and four copies of all comments, reply comments, pleadings, briefs, or other documents shall be furnished the Commission.

6. *Public Inspection of Filings.* All filings made in this proceeding will be available for examination by interested parties during regular business hours in the Commission's Public Reference Room at its headquartes, 1919 M Street, NW., Washington, D.C.

[FR Doc. 85-20887 Filed 8-30-85; 8:45 am]
BILLING CODE 6712-01-M

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## 47 CFR Part 73

**[MM Docket No. 85-260; RM-4955]**

## FM Broadcast Station in Eldon, MO

**AGENCY:** Federal Communications Commission.

**ACTION:** Proposed Rule.

**SUMMARY:** This action proposes the allotment of FM Channel 270A to Eldon, Missouri, in response to a petition filed by Roy D. Williford. The allotment of Channel 270A to Eldon could provide a second FM broadcast service to that community.

**DATES:** Comments must be filed on or before October 18, 1985, and reply comments on or before November 4, 1985.

**ADDRESS:** Federal Communications Commission, Washington, D.C. 20554.

**FOR FURTHER INFORMATION CONTACT:** Kathleen Scheuerle, Mass Media Bureau, (202) 634-6530.

**SUPPLEMENTARY INFORMATION:**

### List of Subjects in 47 CFR Part 73

Radio broadcasting.

The authority citation for Part 73 continues to read:

Authority: Secs. 4 and 303, 48 Stat. 1066, as amended, 1082, as amended; 47 U.S.C. 154, 303. Interpret or apply secs. 301, 303, 307, 48 Stat. 1081, 1082, as amended, 1083, as amended, 47 U.S.C. 301, 303, 307. Other statutory and executive order provisions authorizing or interpreted or applied by specific sections are cited to text.

### Notice of Proposed Rule Making

In the matter of amendment of § 73.202(b), table of allotments FM broadcast stations (Eldon, Missouri); MM Docket No. 85-260, RM-4955.

Adopted: August 13, 1985.
Released: August 27, 1985.

By the Chief, Policy and Rules Division.

1. A petition for rule making has been field by Roy D. Williford ("petitioner"), requesting the allotment of FM channel 270A to Eldon, Missouri, as that community's second FM service. Petitioner has expressed an interest in applying for the channel. The channel can be allocated in compliance with the minimum distance separation requirements of § 73.207 of the Commission's Rules.

### PART 73—[AMENDED]

**§ 73.202 [Amended]**

2. In view of the fact that the proposed allotment could provide a second FM service to Eldon, Missouri, the Commission believes it is appropriate to propose amending the FM Table of Allotments, § 73.202(b) of the Commission's Rules, with respect to the following community:

| City | Channel No. | |
|---|---|---|
| | Present | Proposed |
| Eldon, Missouri | 224A | 224A, 270A |

3. The Commission's authority to institute rule making proceedings, showings required, cut-off procedures, and filing requirements are contained in the attached Appendix and are incorporated by reference herein.

Note.—A showing of continuing interest is required by paragraph 2 of the Appendix before a channel will be allocated.

4. Interested parties may file comments on or before October 18, 1985, and reply comments on or before November 4, 1985, and are advised to read the Appendix for the proper procedures. A copy of such comments should be served on the petitioner as follows: John R. Wilner, Bryan, Cave, McPheeters & McRoberts, 1015 Fifteenth Street, NW., Suite 1000, Washington, D.C. 20005 (Counsel for the petitioner).

5. The Commission has determined that the relevant provisions of the Regulatory Flexibility Act of 1980 do not apply to rule making proceedings to amend the FM Table of Assignments, § 73.202(b) of the Commission's Rules. See, *Certification that sections 603 and 604 of the Regulatory Flexibility Act Do Not Apply to Rule Making to Amend §§ 73.202(b), 73.504 and 73.606(b) of the Commission's Rules*, 46 FR 11549, published February 9, 1981.

6. For further information concerning this proceeding, contact Kathleen Scheurele, Mass Bureau, (202) 634-6530. However, members of the public should note that from the time a Notice of Proposed Rule Making is issued until the

matter is no longer subject to Commission consideration or court review, all *ex parte* contacts are prohibited in Commission proceedings, such as this one, which involve channel assignments. An *ex parte* contact is a message (spoken or written) concerning the merits of a pending rule making other than comments officially filed at the Commission or oral presentation required by the Commission. Any comment which has not been served on the petitioner constitutes an *ex parte* presentation and shall not be considered in the proceeding. Any reply comment which has not been served on the person(s) who filed the comment, to which the reply is directed, constitutes an *ex parte* presentation and shall not be considered in the proceeding.

Federal Communications Commission.

**Charles Schott,**

*Chief, Policy and Rules Division, Mass Media Bureau.*

### Appendix

1. Pursuant to authority found in sections 4(i), 5(d)(1), 303(g) and (r), and 307(b) of the Communications Act of 1934, as amended, and §§ 0.61, 0.204(b) and 0.283 of the Commission's Rules, it is proposed to amend the FM Table of Allotments, § 73.202(b) of the Commission's Rules and Regulations, as set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached.

2. *Showings Required.* Comments are invited on the proposal(s) discussed in the *Notice of Proposed Rule Making* to which this Appendix is attached. Proponent(s) will be expected to answer whatever questions are presented in initial comments. The proponent of a proposed allotment is also expected to file comments even if it only resubmits or incorporates by reference its former pleadings. It should also restate its present intention to apply for the channel if it is alloted and, if authorized, to build a station promptly. Failure to file may lead to denial of the request.

3. *Cut-off Procedures.* The following procedures will govern the consideration of filings in this proceeding.

(a) Counterproposals advanced in this proceeding itself will be considered, if advanced in initial comments, so that parties may comment on them in reply comment. They will not be considered if advanced in reply comments. (See § 1.420(d) of the Commission's Rules.)

(b) With respect to petitions for rule making which conflict with the proposal(s) in this *Notice*, they will be considered as comments in the proceeding, and Public Notice to this effect will be given as long as they are filed before the date for filing initial comments herein. If they are filed later than that, they will not be considered in connection with the decision in this docket.

(c) The filing of a counterproposal may lead the Commission to allot a different channel than was requested for any of the communities involved.

4. *Comments and Reply Comments; Service.* Pursuant to applicable procedures set out in §§ 1.415 and 1.420 of the Commission's Rules and Regulations, interested parties may file comments and reply comments on or before the dates set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached. All submissions by parties to this proceeding or persons acting on behalf of such parties must be made in written comments, reply comments, or other appropriate pleadings. Comments shall be served on the petitioner by the person filing the comments. Reply comments shall be served on the person(s) who filed comments to which the reply is directed. Such comments and reply comments shall be accompanied by a certificate of service. (See § 1.420 (a), (b) and (c) of the Commission's Rules.)

5. *Number of Copies.* In accordance with the provisions of § 1.420 of the Commission's Rules and Regulations, an original and four copies of all comments, reply comments, pleadings, briefs, or other documents shall be furnished the Commission.

6. *Public Inspection of Filings.* All filings made in this proceeding will be available for examination by interested parties during regular business hours in the Commission's Public Reference Room at its headquarters, 1919 M Street, NW., Washington, D.C.

[FR Doc. 85-20690 Filed 8-30-85; 8:45 am]
BILLING CODE 6712-01-M

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## 47 CFR Part 73

**[MM Docket No. 85-259; RM-4956]**

## FM Broadcast Station in Mt. Pleasant, MI

**AGENCY:** Federal Communications Commission.

**ACTION:** Proposed rule.

**SUMMARY:** This action proposes the allotment of FM Channel 282A to Mount Pleasant, Michigan, in response to a petition filed by Great Lakes Radio Corporation. This allotment could provide a second commercial service for the community.

**DATES:** Comments must be filed on or before October 18, 1985, and reply comments on or before November 4, 1985.

**ADDRESS:** Federal Communications Commission, Washington, D.C. 20554.

**FOR FURTHER INFORMATION CONTACT:** Kathleen Scheuerle, Mass Media Bureau, (202) 634-6530.

**SUPPLEMENTARY INFORMATION:**

### List of Subjects in 47 CFR Part 73

Radio broadcasting.

The authority citation for Part 73 continues to read:

Authority: Secs. 4 and 303, 48 Stat. 1066, as amended, 1082, as amended; 47 U.S.C. 154, 303. Interpret or apply secs. 301, 303, 307, 48 Stat. 1081, 1082, as amended, 1083, as amended, 47 U.S.C. 301, 303, 307. Other statutory and executive order provisions authorizing or interpreted or applied by specific sections are cited to text.

### Notice of Proposed Rule Making

In the matter of amendment of § 73.202(b), table of allotments, FM broadcast stations (Mt. Pleasant, Michigan); MM Docket No. 85-259, RM-4956.

Adopted: August 13, 1985.
Released: August 27, 1985.

By the Chief, Policy and Rules Division.

1. A petition for rule making has been filed by Great Lakes Radio Corporation ("petitioner"), seeking the allotment of FM Channel 282A at Mt. Pleasant, Michigan, as that community's second commercial broadcast service. Petitioner submitted information in support of the proposal and stated that it would apply for the channel, if allocated.

2. Channel 282A can be allocated to Mt. Pleasant, Michigan, consistent with the minimum distance separation requirements of the Commission's Rules. Since the allotment of Channel 282A to Mt. Pleasant is within 320 kilometers (200 miles) of the common U.S.-Canadian border, concurrence of the Canadian government is required.

### PART 73—[AMENDED]

**§ 73.2021 [Amended]**

3. In view of the fact that the proposed allocation could provide a second FM broadcast service to Mt. Pleasant, Michigan, the Commission believes it is appropriate to propose amending the FM Table of Allotments, § 73.202(b) of the Commission's Rules, with respect to the following community:

| City | Channel No. | |
|---|---|---|
| | Present | Proposed |
| Mt. Pleasant, Michigan | 233 | 233, 282A |

4. The Commission's authority to institute rule making proceedings, showings required, cut-off procedures, and filing requirements are contained in the attached Appendix and are incorporated by reference herein.

Note: A showing of continuing interest is required by paragraph 2 of the Appendix before a channel will be allotted.

5. Interested parties may file comments on or before October 18, 1985, and reply comments on or before November 4, 1985, and are advised to read the Appendix for the proper procedures. Additionally, a copy of such comments should be served on the petitioners, or their counsel or consultant, as follows: Lauren A. Colby, 10 East Fourth Street, P.O. Box 113, Frederick, MD 21701. (Counsel for petitioner).

6. The Commission has determined that the relevant provisions of the Regulatory Flexibility Act of 1980 do not apply to rule making proceedings to amend the FM Table of Allotments, § 73.202(b) of the Commission's Rules. See, *Certification that sections 603 and 604 of the Regulatory Flexibility Act Do Not Apply to Rule Making to Amend §§ 73.202(b), 73.504 and 73.606(b) of the Commission's Rules*, 46 FR 11549, published February 9, 1981.

7. For further information concerning this proceeding, contact Kathleen Scheuerle, Mass Media Bureau, (202) 634–6530. However, members of the public should note that from the time a Notice of Proposed Rule Making is issued until the matter is no longer subject to Commission consideration or court review, all *ex parte* contacts are prohibited in Commission proceedings, such as this one, which involve channel allotments. An *ex parte* contact is a message (spoken or written) concerning the merits of a pending rule making, other than comments officially filed at the Commission, or oral presentation required by the Commission. Any comment which has not been served on the petitioner constitutes an *ex parte* presentation and shall not be considered in the proceeding. Any reply comment which has not been served on the person(s) who filed the comment, to which the reply is directed, constitutes an *ex parte* presentation and shall not be considered in the proceeding.

Federal Communications Commission.

**Charles Schott,**

*Chief, Policy and Rules Division, Mass Media Bureau.*

1. Pursuant to authority found in sections 4(i), 5(d)(1), 303(g) and (r), and 307(b) of the Communications Act of 1934, as amended, and §§ 0.61, 0.204(b) and 0.283 of the Commission's Rules, it is proposed to amend the FM Table of Allotments, § 73.202(b) of the Commission's Rules and Regulations, as set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached.

2. *Showings Required.* Comments are invited on the proposal(s) discussed in the *Notice of Proposed Rule Making* to which this Appendix is attached. Proponent(s) will be expected to answer whatever questions are presented in initial comments. The proponent of a proposed allotment is also expected to file comments even if it only resubmits or incorporates by reference its former pleadings. It should also restate its present intention to apply for the channel if it is allotted and, if authorized, to build a station promptly. Failure to file may lead to denial of the request.

3. *Cut-off Procedures.* The following procedures will govern the consideration of filings in this proceeding.

(a) Counterproposals advanced in this proceeding itself will be considered, if advanced in initial comments, so that parties may comment on them in reply comments. They will not be considered if advanced in reply comments. (See § 1.420(d) of the Commission's Rules.)

(b) With respect to petitions for rule making which conflict with the proposal(s) in this *Notice*, they will be considered as comments in the proceeding, and Public Notice to this effect will be given as long as they are filed before the date for filing initial comments herein. If they are filed later than that, they will not be considered in connection with the decision in this docket.

(c) The filing of a counterproposal may lead the Commission to allot a different channel than was requested for any of the communities involved.

4. *Comments and Reply Comments; Service.* Pursuant to applicable procedures set out in §§ 1.415 and 1.420 of the Commission's Rules and Regulations, interested parties may file comments and reply comments on or before the dates set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached. All submissions by parties to this proceeding or persons acting on behalf of such parties must be made in written comments, reply comments, or other appropriate pleadings. Comments shall be served on the petitioner by the person filing the comments. Reply comments shall be served on the person(s) who filed comments to which the reply is directed. Such comments and reply comments shall be accompanied by a certificate of service. (See § 1.420(a), (b) and (c) of the Commission's Rules.)

5. *Number of Copies.* In accordance with the provisions of § 1.420 of the Commission's Rules and Regulations, an original and four copies of all comments, reply comments, pleadings, briefs, or other documents shall be furnished the Commission.

6. *Public Inspection of Filings.* All filings made in this proceeding will be available for examination by interested parties during regular business hours in the Commission's Public Reference Room at its headquarters, 1919 M Street, NW., Washington, D.C.

[FR Doc. 85–20888 Filed 8–30–85; 8:45 am]
BILLING CODE 6712-01-M

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## 47 CFR Part 73

**[MM Docket No. 85–263; RM–4957]**

## FM Broadcast Station in Macon, MS

**AGENCY:** Federal Communications Commission.

**ACTION:** Proposed rule.

**SUMMARY:** This action proposes the allotment of FM Channel 263A to Macon, Mississippi, in response to a petition filed by Double 'H' Broadcasting Company. This allotment could provide for a first FM service for the community.

**DATES:** Comments must be filed on or before October 18, 1985, and reply comments on or before November 4, 1985.

**ADDRESS:** Federal Communications Commission, Washington, D.C. 20554.

**FOR FURTHER INFORMATION CONTACT:** Kathleen Scheuerle, Mass Media Bureau, (202) 634–6530.

**SUPPLEMENTARY INFORMATION:**

### List of Subjects in 47 CFR Part 73

Radio broadcasting.

The authority citation for Part 73 continues to read:

Authority: Secs. 4 and 303, 48 Stat. 1066, as amended, 1082, as amended; 47 U.S.C. 154, 303. Interpret or apply secs. 301, 303, 307, 48 Stat. 1081, 1082, as amended, 1083, as amended, 47 U.S.C. 301, 303, 307. Other statutory and executive order provisions authorizing or interpreted or applied by specific sections are cited to text.

### Notice of Proposed Rule Making

In the matter of amendment of § 73.202(b), table of allotments, FM broadcast stations (Macon, Mississippi): MM Docket No. 85–263, RM–4957.

Adopted: August 13, 1985.
Released: August 27, 1985.

By the Chief, Policy and Rules Division.

1. A petition for rule making has been filed by Double 'H' Broadcasting Company ("petitioner"), seeking the allotment of FM Channel 263A to Macon, Mississippi, as that community's first broadcast service. Petitioner submitted information in support of the proposal and stated that it would apply for the channel.

2. Channel 263A can be allocated to Macon, Mississippi, consistent with the minimum distance requirements of the Commission's Rules.

**PART 73—[AMENDED]**

**§ 73.202 [Amended]**

3. In view of the fact that the proposed assignment could provide a first FM broadcast service to Macon, Mississippi, the Commission believes it is appropriate to propose amending the FM Table of Allotments, § 73.202(b) of the Commission's Rules, with respect to the following community:

| City | Channel No. | |
|---|---|---|
| | Present | Proposed |
| Macon, MS | | 263A |

4. The Commission's authority to institute rule making proceedings, showings required, cut-off procedures, and filing requirements are contained in the attached Appendix and are incorporated by reference herein.

Note: A showing of continuing interest is required by paragraph 2 of the Appendix before a channel will be allotted.

5. Interested parties may file comments on or before October 18, 1985, and reply comments on or before November 4, 1985, and are advised to read the Appendix for the proper procedures. Additionally, a copy of such comments should be served on the petitioners, or their counsel or consultant, as follows:

L. Lynn Henley, Partner, double 'H' Broadcasting Co., Rt. 3, Box 865, Macon, Mississippi 39341

Larry G. Fuss, Sr., Contemporary Communications, P.O. Box 3976, Jackson, Georgia 30233-0976 (consultant to petitioner)

6. The Commission has determined that the relevant provisions of the Regulatory Flexibility Act of 1980 do not apply to rule making proceedings to amend the FM Table of Allotments, § 73.202(b) of the Commission's Rules. See, *Certification that sections 603 and 604 of the Regulatory Flexibility Act Do Not Apply to Rule Making to Amend §§ 73.202(b), 73.504 and 73.606(b) of the Commission's Rules*, 46 FR 11549, published February 9, 1981.

7. For further information concerning this proceeding, contact Kathleen Scheuerle, Mass Media Bureau, (202) 634-6530. However, members of the public should note that from the time a Notice of Proposed Rule Making is issued until the matter is no longer subject to Commission consideration or court review, all *ex parte* contacts are prohibited in Commission proceedings, such as this one, which involve channel allotments. An *ex parte* contact is a message (spoken or written) concerning the merits of a pending rule making, other than comments officially filed at the Commission, or oral presentation required by the Commission. Any comment which has not been served on the petitioner constitutes an *ex parte* presentation and shall not be considered in the proceeding. Any reply comment which has not been served on the person(s) who filed the comment, to which the reply is directed, constitutes and *ex parte* presentation and shall not be considered in the proceeding.

Federal Communications Commission.

**Charles Schott,**

*Chief, Policy and Rules Division, Mass Media Bureau.*

1. Pursuant to authority found in sections 4(i), 5(d)(1), 303 (g) and (r), and 307(b) of the Communications Act of 1934, as amended, and §§ 0.61, 0.204(b) and 0.283 of the Commission's Rules, it is proposed to amend the FM Table of Allotments, § 73.202(b) of the Commission's Rules and Regulations, as set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached.

2. *Showings Required.* Comments are invited on the proposal(s) discussed in the *Notice of Proposed Rule Making* to which this Appendix is attached. Proponent(s) will be expected to answer whatever questions are presented in initial comments. The proponent of a proposed allotment is also expected to file comments even if it only resubmits or incorporates by reference its former pleadings. It should also restate its present intention to apply for the channel if it is allotted and, if authorized, to build a station promptly. Failure to file may lead to denial of the request.

3. *Cut-off Procedures.* The following procedures will govern the consideration of filings in this proceeding.

(a) Counterproposals advanced in this proceeding itself will be considered, if advanced in initial comments, so that parties may comment on them in reply comments. They will not be considered if advanced in reply comments. (See § 1.420(d) of the Commission's Rules.)

(b) With respect to petitions for rule making which conflict with the proposal(s) in this *Notice*, they will be considered as comments in the proceeding, and Public Notice to this effect will be given as long as they are filed before the date for filing initial comments herein. If they are filed later than that, they will not be considered in connection with the decision in this docket.

(c) The filing of a counterproposal may lead the Commission to allot a different channel than was requested for any of the communities involved.

4. *Comments and Reply Comments; Service.* Pursuant to applicable procedures set out in §§ 1.415 and 1.420 of the Commission's Rules and Regulations, interested parties may file comments and reply comments on or before the dates set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached. All submissions by parties to this proceeding or persons acting on behalf of such parties must be made in written comments, reply comments, or other appropriate pleadings. Comments shall be served on the petitioner by the person filing the comments. Reply comments shall be served on the person(s) who filed comments to which the reply is directed. Such comments and reply comments shall be accompanied by a certificate of service. (See § 1.420 (a), (b) and (c) of the Commission's Rules.)

5. *Number of Copies.* In accordance with the provisions of § 1.420 of the Commission's Rules and Regulations, an original and four copies of all comments, reply comments, pleadings, briefs, or other documents shall be furnished the Commission.

6. *Public Inspection of Filings.* All filings made in this proceeding will be available for examination by interested parties during regular business hours in the Commission's Public Reference Room at its headquarters, 1919 M Street, NW., Washington, D.C.

[FR Doc. 85-20889 Filed 8-30-85; 8:45 am]

BILLING CODE 6712-01-M

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## GENERAL SERVICES ADMINISTRATION

**48 CFR Parts 549 and 552**

**[GSAR Notice No. 5-103]**

**Termination for Convenience of Government and Termination Liabilities**

**AGENCY:** Office of Acquisition Policy, GSA.

**ACTION:** Notice of proposed rulemaking.

**SUMMARY:** This notice invites written comments on a proposed change to the General Services Administration Acquisition Regulation (GSAR) Chapter 5, that would add sections 549.502, Termination for Convenience of the Government; 552.249–1, Termination for Convenience of the Government (Fixed-Price) (Short Form); 552.249–2, Termination for Convenience of the Government (Fixed-Price); and 552.249–70, Submission of Termination of Liability Schedule. The GSA Office of Information Resources Management has obtained a class deviation from the application of the Federal Acquisition Regulations (FAR) Termination for Convenience of the Termination clauses at sections 52.249–1 and 52.249–2 to contracts for the acquisition of telephone systems which are funded through the Federal Telecommunications (FT) Fund. The deviation provides for modification of the FAR clauses in order to make them compatible with a termination liability provision. The deviation also provides for the inclusion of a termination liability provision in such contracts. This proposed change to the GSAR would incorporate the substance of the class deviation into the regulation. The intended effect is to improve the regulatory coverage and to provide uniform procedures for contracting under the regulatory system.

**DATES:** Comments are due in writing not later than October 3, 1985.

**ADDRESS:** Requests for a copy of the proposal and your comments should be addressed to Ms. Ida M. Ustad, Office of GSA Acquisition Policy and Regulations, 18th and F Streets, NW., Room 4027, Washington, D.C. 20405.

**FOR FURTHER INFORMATION CONTACT:** Ms. Ida Ustad, Office of GSA Acquisition Policy and Regulations, (202) 523–4754.

**SUPPLEMENTARY INFORMATION:** This is not a major rule as defined in Executive Order 12291. Therefore, preparation of a regulatory impact analysis was not necessary. The General Services Administration (GSA) certifies that this document will not have a significant economic effect on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 et. seq.). Therefore, no regulatory flexibility analysis has been prepared. Under the proposed rule, GSA would follow the standard telephone industry practice regarding the use of termination liability provisions.

The information collection requirements contained in this rule have been submitted to OMB for approval under the Paperwork Reduction Act (44 U.S.C. 3501 et. seq.).

**List of Subjects in 48 CFR Parts 549 and 552**

Government procurement.

Dated: August 5, 1985.

**Richard H. Hopf III,**

*Director, Office of GSA Acquisition Policy and Regulations.*

[FR Doc. 85–20905 Filed 8–30–85; 8:45 am]

BILLING CODE 6820–61–M

## DEPARTMENT OF TRANSPORTATION

### National Highway Traffic Safety Administration

### 49 CFR Part 571

**[Docket No. 85–10; Notice 1]**

### Federal Motor Vehicle Safety Standards; Lamps, Reflective Devices, and Associated Equipment

**AGENCY:** National Highway Traffic Safety Administration (NHTSA), DOT.

**ACTION:** Notice of proposed rulemaking.

**SUMMARY:** Motor Vehicle Lamp Test Bulbs. This notice proposes an amendment to Safety Standard No. 108 that would delete paragraph § 4.1.1.20 which specifies that certain motor vehicle lighting equipment be tested with a bulb whose filament is positioned within ±0.010 inch of the nominal design position specified in SAE Standard J573d. The reasons for the proposal are the difficulty that manufacturers have in obtaining bulbs of this calibration, and the fact that the test bulb may not be representative of the bulb with which the lamp is sold. Deletion of this requirement would allow a manufacturer to test with a production bulb of a tolerance of ±0.040 inch. The proposal implements the grant of a rulemaking petition submitted by Dry Launch Light Company.

**DATES:** The comment closing date for the proposal is October 18, 1985. Effective date of the amendment would be six months after publication of the final rule in the **Federal Register.** Any request for an extension of time in which to comment must be received not later than 10 days before the published expiration date of the comment period (49 CFR 553.19).

**ADDRESS:** Comments should refer to the docket number and notice number and be submitted to: Docket Section, NHTSA, Room 5109, 400 Seventh Street, SW., Washington, DC 20590 (Docket hours are from 8 a.m. to 4 p.m.).

**FOR FURTHER INFORMATION CONTACT:** Ken Rutland, Office of Rulemaking, National Highway Traffic Safety Administration, 400 Seventh Street, SW., Washington, DC 20590 (202–426–2153).

**SUPPLEMENTARY INFORMATION:** On June 21, 1973, Motor Vehicle Safety Standard No. 108 was amended to add paragraph § 4.1.1.20 (38 FR 16230), effective January 1, 1984. That paragraph states in pertinent part that a lamp not having a sealed-in bulb shall meet Standard No. 108 "when tested with a bulb whose filament is positioned within ±0.010 inch of the nominal design position specified in SAE Standard J573d, 'Lamps, Bulbs and Sealed Units', December 1968, or specified by the bulb manufacturer".

The preamble to the amendment gave the rationale for the adoption of this requirement, reporting that instances had arisen where noncompliances of lamps could not be proven in marginal cases because of the filament tolerances permitted in test bulbs. The amendment sought to render test results more reproducible by adoption of a strict filament tolerance. Although the proposal was supported, concern was voiced at the time that it would be difficult to obtain test bulbs with such a narrow tolerance. NHTSA, however, found that those alleged difficulties were outweighed by the need for objective and repeatable tests that would be obtained with a finely calibrated test bulb. It advised that a manufacturer need not test with such a bulb if it had test data to show a correlation between the Standard No. 108 test bulb and one that it may have used outside that tolerance, and that certification could be based on the test data and the correlation factor, assuming that that factor indicated compliance.

Dry Launch Light Company, a division of Sierra Products, Inc., Livermore, California, has petitioned for rulemaking to delete paragraph § 4.1.1.20 for two basic reasons: the first, its continued difficulties in obtaining a test bulb of the specified tolerance, and the second, the inconsistency represented in testing a lamp with one tolerance, and equipping it with a bulb that will have a different one. It suggested adoption of a "real life" approval such as SAE Recommended Practice J256 "Service Performance Requirements for Motor Vehicle Safety Devices and Components". NHTSA has granted that petition.

NHTSA has determined that test bulbs of the specified tolerance are available, albeit expensive and limited in production. Nevertheless, it has

tentatively decided that motor vehicle safety may be better served by deleting the requirement so that compliance may be judged with a bulb representative of those with which a lamp is equipped when sold to the public for use on the roads. These bulbs will be those in general use by the industry, almost invariably those that are listed in SAE Standard J575d. The tolerance permitted by SAE J573d is ±0.040 inch. If a lamp is equipped with a bulb that is not listed in SAE J573 and has not been assigned a mean spherical candlepower rating, § 4.1.1.19 requires it to meet Standard No. 108 when used with any bulb of the type specified by the lamp manufacturer.

The agency is aware that lamp manufacturers may object that the proposal will require them to insure photometrics for a wider range of bulb tolerances. This is true, and is exactly what the agency intends. But NHTSA has concluded that this ought not to be burdensome. It contracted with ETL Testing Laboratories, Inc. to perform a study comparing test results for stoplamps with an accurate rated bulb with a tolerance of ±0.010 inch and one with a tolerance exceeding 0.040 inch. Interpolating to correlate with a 0.040 inch tolerance, the change in performance resulting from increasing the tolerance was judged of such a nature as not to affect conformance. A copy of this report has been placed in the docket.

NHTSA has concluded that it does not appear necessary to adopt SAE J256 since, in essence, its zonal method has been adopted in Figures 1 and 2 of Standard No. 108 for parking, tail, stop, turn signal, and backup lamps.

NHTSA has considered this proposal and has determined that it is not major within the meaning of Executive Order 12291 "Federal Regulation" or significant under Department of Transportation regulatory policies and procedures. The agency has also determined that neither a regulatory impact analysis nor a full regulatory evaluation is required. The proposed change should have no impact upon the cost of the lamp since it is directed towards a modification of a test procedure and not towards a modification in the lamp or its light source.

NHTSA has analyzed this proposal for the purposes of the National Environmental Policy Act. The proposal would have no effect on the human environment since the weight and quantity of materials used in the manufacture of lamps will not be changed.

The agency has also considered the impacts of this proposal in relation to the Regulatory Flexibility Act. I certify that this proposal would not have a significant economic impact on a substantial number of small entities. Accordingly, no initial regulatory flexibility analysis has been prepared. Manufacturers of motor vehicle lighting equipment, those affected by the proposal, are generally not small businesses within the meaning of the Regulatory Flexibility Act. Finally small organizations and governmental jurisdictions would not be significantly affected since the price of new lamps will be minimally impacted.

Interested persons are invited to submit comments on the proposal. It is requested but not required that 10 copies be submitted.

All comments must be limited not to exceed 15 pages in length. (49 CFR 553.21) Necessary attachments may be appended to these submissions without regard to the 15-page limit. This limitation is intended to encourage commenters to detail their primary arguments in concise fashion.

If a commenter wishes to submit certain information under a claim of confidentiality, three copies of the complete submission, including purportedly confidential information, should be submitted to the Chief Counsel, NHTSA, at the street address given above, and seven copies from which the purportedly confidential information has been deleted should be accompanied by a cover letter setting forth the information specified in the agency's confidential business information regulation (49 CFR Part 512).

All comments received before the close of business on the comment closing date indicated above will be considered and will be available for examination in the docket at the above address both before and after that date. To the extent possible, comments filed after the closing date will also be considered. However, the rulemaking action may proceed at any time after that date, and comments received after the closing date and too late for consideration in regard to the action will be treated as suggestions for future rulemaking. The NHTSA will continue to file relevant material as it becomes available in the docket after the closing date and it is recommended that interested persons continue to examine the docket for new material.

Those persons desiring to be notified upon receipt of their comments in the rules docket should enclose, in the envelope with their comments, a self-addressed stamped postcard. Upon receiving the comments, the docket supervisor will return the postcard by mail.

The engineer and lawyer primarily responsible for this proposal are Ken Rutland and Taylor Vinson, respectively.

**List of Subjects in 49 CFR Part 571**

Imports, Motor vehicle safety, Motor vehicles, Rubber products, Tires.

In consideration of the foregoing, it is proposed that 49 CFR 571.108, Motor Vehicle Safety Standard No. 108, *Lamps Reflective Devices, and Associated Equipment*, be amended as follows:

**PART 571—[AMENDED]**

1. The authority citation for Part 571 would continue to read as follows:

**Authority:** 15 U.S.C. 1392, 1401, 1403, 1407 delegation of authority at 49 CFR 1.50.

**§ 571.108 [Amended]**

* * * * *

2. Paragraph S4.1.1.20 would be removed.

Issued on August 28, 1985.

**Barry Felrice,**

*Associate Administrator for Rulemaking.*

[FR Doc. 85-20949 Filed 8-30-85; 8:45 am]

BILLING CODE 4910-59-M

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**DEPARTMENT OF THE INTERIOR**

**Fish and Wildlife Service**

**50 CFR Part 17**

## Endangered and Threatened Wildlife and Plants; Proposal To Determine Iliamna Corei (Peter's Mountain Mallow) To Be an Endangered Species

**AGENCY:** Fish and Wildlife Service, Interior.

**ACTION:** Proposed rule.

**SUMMARY:** The Service proposes to list *Iliamna corei* (Peter's Mountain Mallow) as an endangered species. This plant species occurs as a single population in western Virginia. Its continued existence is threatened by the encroachment of competing vegetation, habitat degradation, and low reproductive potential. The population, which occurs on private land, was also reduced in total area and number of plants by construction of a hiking trail in the early 1970's. Although the trail has now been abandoned, hikers occasionally follow the old path through the colony. Listing as endangered would provide the species protection under the Endangered Species Act of 1973, as amended. The Service seeks comments

and further information concerning this proposal.

**DATES:** Comments from all interested parties must be received by November 4, 1985. Public hearing requests must be received by October 18, 1985.

**ADDRESS:** Comments and materials concerning this proposal should be sent to: Regional Director, U.S. Fish and Wildlife Service, One Gateway Center, Suite 700, Newton Corner, Massachusetts 02158. Comments and materials received will be available for public inspection, by appointment, during normal business hours at the above address.

**FOR FURTHER INFORMATION CONTACT:** Richard W. Dyer at the above address (617/965–5100 or FTS 829–9316).

**SUPPLEMENTARY INFORMATION:**

## Background

Peter's Mountain Mallow is a member of the Malvaceae (mallow family) and is presently known to exist in only one small population in western Virginia. The population occurs on private land near the summit of Peter's Mountain in Giles County. The perennial plants are 20 to 36 inches (0.5 to 0.9 meters) tall and appear somewhat like small hollyhocks with large rose or light pink flowers 1 to 2 inches (2.5 to 5.0 centimeters) across. The flowers have no fragrance and appear in late July and August. The short-stalked flowers occur in terminal clusters or in the axils of the upper leaves.

When the population was first discovered by Dr. Earl Core in 1927 (Strausbaugh and Core, 1932), approximately 50 plants were growing vigorously in the soil-filled pockets and crevices of an exposed sandstone outcrop. The plants were in full sunlight and produced an "abundant supply of seeds." The Peter's Mountain site was visited periodically in ensuing years and "40 clumps, with 1 to 15 plants in each clump" were counted in 1962 (Keener and Hardin, 1962). The plants were noted as being scattered through a 150 by 30 foot (45 by 9 meters) area following the ridge contour. Although the interpretation and counting of clumps, stems, or plants has not been uniformly applied over the years, there is little doubt that the population has declined considerly, as only 5 plants and 55 stems were observed in July, 1984.

Considerable debate has existed among botanists as to the taxonomic distinction between *Iliamna corei* and a closely related species, *Iliamna remota*, which is also a candidate for Federal listing. Because of the confusion, significant points in the taxonomic history of these two taxa will be summarized. The first collections of *Iliamna remota* were made in 1872, by E.J. Hill, on a gravelly island in the Kankakee River near Altorf, Illinois. The distinct nature of the species was not recognized at that time and the plants were identified as a western species of mallow, *Sphaeralcea acerifolia*, which occurs in the Rocky Mountains from Colorado to British Columbia. In 1899, Dr. Edward L. Green examined the Illinois plants, recognized differences between them and the widespread western species, and called the Kankakee River plants *Iliamna remota*. Meritt L. Fernald transferred the Kankakee plants to the related genus *Spaeralcea* under the name *Sphaeralcea remota* in the seventh edition of *Gray's Manual of Botany* (Fernald, 1908). Seeking to clarify the situation for the second edition of *An Illustrated Flora of the United States, Canada and the British Possessions from Newfoundland to the Parallel of the Southern Boundary of Virginia and from the Atlantic Ocean Westward to the 102nd Meridian*, Nathaniel Lord Britton called upon Earl E. Sherff for assistance in obtaining specimens from the Kankakee Island site. Sherff visited the site with the original discoverer, Mr. Hill, in 1912. They found a vigorous colony and obtained several plants for analysis. Dr. Britton then named the species as *Phymosia remota*.

Twenty years then passed before P.D. Strausbaugh and Dr. Earl Core published an account (Strausbaugh and Core, 1932) of Dr. Core's discovery of *Phymosia remota* on Peter's Mountain in August of 1927. Dr. Sherff was particularly interested in reading of the discovery because of the remarkable distance between the two populations and the differences in habitat types, i.e., mountain outcrop versus river island. Of equal interest to Sherff was a statement in the article that reported the Kankakee River population as having been destroyed.

Sherff returned to the Kankakee River site in 1945, discovered "hundreds of plants flourishing" on the now abandoned island, and began a detailed study comparing the Illinois and Virginia populations. Dr. Sherff concluded that the Peter's Mountain and the Kankakee River plants appropriately belonged to the same species, but that the Virginia plants were a different variety, which he named *Iliamna remota* var. *corei* (Sherff, 1946). Later he concluded in fact that they were two separate species and in 1949 named the Peter's Mountain plants *Iliamna corei* (Sherff, 1949). Sherff's work has been the most comprehensive published analysis to date of the two populations. Although Kartesz (Kartesz and Kartesz, 1980) synonomized *Iliamna corei* under *Iliamna remota*, there appears to be no definitive and specific work on which to base that conclusion. The most recent work was conducted by William A. Pusateri, while a graduate student at Miami University. Mr. Pusateri is continuing his studies using more advanced techniques, including electrophoresis and chromosome analysis. Although he has not yet completed his investigations, he is of the opinion that Sherff's conclusion on the distinctiveness of the two species is correct (Pusateri, personal communication).

*Iliamna corei* was recognized as a "category-1" candidate for Federal listing in the Service's **Federal Register** notice of review of plant taxa for listing as endangered or threatened on December 15, 1980 (45 FR 82480). Category-1 taxa were defined as species for which sufficient information was on hand to support the biological appropriateness of proposing to list. The Endangered Species Act Amendments of 1982 required that all petitions pending as of October 13, 1982 be treated as having been newly submitted on that date. The species covered by the December 15, 1980, notice are treated as if under petition, and the deadline for making a finding on such species, including *Iliamna corei*, was October 13, 1983. On October 13, 1983, and again on October 12, 1984, the petition finding was made that listing of *Iliamna corei* was warranted, but precluded by other pending listing actions, in accordance with section 4(b)(3)(B)(iii) of the Act. Notice of the 1983 finding was published on January 20, 1984 (49 FR 2485). Such a finding requires a recycling of the petition pursuant to section 4(b)(3)(c)(i) of the Act. Consequently, a new finding must be made on or before October 13, 1985; this proposed rule constitutes the finding that the listing of this species is warranted and proposes to implement the action, in accordance with section 4(b)(3)(B)(ii) of the Act.

Based on the continuing decline and the now precarious existence of the Peter's Mountain population of *Iliamna corei*, the Service considers that listing under the Act is warranted. Although *Iliamna remota* is also a candidate for Federal listing, sufficient information is not on hand to justify a proposal at this time. At least three wild or perhaps introduced populations of *Iliamna remota* are known to exist, and the literature refers to additional populations being established in home gardens and other "secure places." The original Kankakee River island site is

also now protected as a State ecological preserve.

**Summary of Factors Affecting the Species**

Section 4(a)(1) of the Endangered Species Act (16 U.S.C. 1531 *et seq.*) and regulations promulgated to implement the listing provisions of the Act (49 FR 38900, October 1, 1984, codified at 50 CFR Part 424) set forth the procedures for adding species to the Federal lists. A species may be determined to be an endangered or threatened species due to one or more of the five factors described in section 4(a)(1). These factors and their application in *Iliamna corei* Sherff (Peter's Mountain mallow) are as follows:

A. *The present or threatened destruction, modification, or curtailment of its habitat or range.* Habitat degradation is the primary threat to the continued existence of *Iliamna corei*. The encroachment of competing vegetation and the subsequent reduction of direct sunlight reaching the plants appear to be major factors in the reduced size and reproductive vigor of the population. Historical references indicate that the population on the sandstone outcrop was previously open to a great deal more direct sunlight than is the case today. The growth of the forest canopy has been a factor, but the major threat is competition from an introduced herbaceous species, *Polymnia canadensis* (Canadian leafcup). Previous publications that list the woody and herbaceous plants growing in association with *Iliamna corei* (e.g., Keener and Hardin, 1962) make no reference to the leafcup, which now dominates the site. How the leafcup became established is open to speculation, but establishment could have been expedited by the completion of a nearby power transmission line or the construction of a hiking trail. Although the trail has now been abandoned, a number of *Iliamna* plants were destroyed when the trail was built through the colony.

B. *Overutilization for commercial, recreational, scientific, or educational purposes.* Scientific collecting has been a problem, as many botanists have visited the site since the original discovery in 1927 to collect herbarium specimens. Local professors and students have visited the site for educational purposes.

The populations was once more vigorous and larger in numbers and in size, and some collecting might have been tolerated. Any further collecting, however, could be extremely detrimental. There is no known record of collection for commercial purposes; however, whole plants, fruits, and seeds have been taken for private purposes, particularly for home gardens.

C. *Disease or predation.* Disease has not been a factor, but could become so due to the vulnerability of the extremely small population. White-tailed deer have also been known to browse the plants to some extent but do not appear to be a significant factor in reducing or suppressing the population.

D. *The inadequacy of existing regulatory mechanisms.* The Commonwealth of Virginia does not presently list *Iliamna corei* under protection of the Endangered Plant and Insect Act. Under the State law, it is unlawful to dig, cut, process or collect, remove, transport, possess, sell, offer for sale, or give away listed plants other than from one's own land. Because the Federal Endangered Species Act does not prohibit the taking of endangered or threatened plants on non-Federal lands, the listing of *Iliamna corei* under State law would provide an important degree of proteciton. The authority to list plants under the State law is vested in the Virginia Assembly.

E. *Other natural or man-made factors affecting its continued existence.* Because of the small size of the only known population, its lack of vigor, and its presently low reproductive potential, a number of chance events such as fire, insect infestation or intensive browsing could become sigificant factors in the species' continued existence.

The Service has carefully assessed the best scientific information available regarding the past, present, and future threats faced by this species in determining to propose this rule. Based on this evaluation, the preferred action it to list *Iliamna corei* as endangered. Due to the continuing decline of the only known population and the rapid encroachment of competing vegetation, the plants are particularly vulnerable and in need of protection. Critical habitat is not proposed for this species for the reasons enumerated below.

**Critical Habitat**

Section 4(a)(3) of the Act, as amended, requires that to the maximum extent prudent and determinable, the Secretary designate any habitat of a species which is considered to be critical habitat at the time the species is determined to be endangered or threatened. The Service considers designation of critical habitat to be prudent when such designation will benefit the species involved. Due to the extremely small size of the existing population and the documented history of taking the plant for private cultivation and/or scientific purposes, the Service finds that designation of critical habitat is not prudent at this time. Publication of detailed habitat descriptions and maps could expose the species to more intense horticultural collecting, vandalism, or trampling by curiosity seekers. Designation of critical habitat would therefore not be likely to benefit the species' conservation.

**Available Conservation Measures**

Conservation measures provided to species listed as endangered or threatened under the Endangered Species Act include recognition, recovery actions, requirements for Federal protection, and prohibitions against certain practices. Recognition through listing encourages and results in conservation actions by Federal and State agencies and private conservation organizations and individuals. The Nature Conservancy has discussed protection strategies with the private individual who owns the land upon which this species occurs, and talks are continuing in hopes of achieving a formal protection agreement. Other conservation measures, including required protection efforts by Federal agencies and prohibitions against taking are discussed, in part, below.

Section 7(a) of the Act, as amended, requires Federal agencies to evaluate their actions with respect to any species that is proposed or listed as endangered or threatened, and with respect to its critical habitat, if any is being designated. Regulations implementing this interagency cooperation provision of the Act are codified at 50 CFR Part 402, and are now under revision (see proposal at 48 FR 29990, June 29, 1983). Section 7(a)(4) requires Federal agencies to confer informally with the Service an any action that is likely to jeopardize the continued existence of a proposed species or destroy or adversely modify and area proposed to be designated as critical habitat. If a species is subsequently listed, section 7(a)(2) requires Federal agencies to ensure that activities they authorize, fund, or carry out are not likely to jeopardize the continued existence of such a species or destroy or adversely modify its critical habitat. If a Federal action may affect a listed species or its critical habitat, the responsible Federal agency must enter into formal consultation with the Service. Currently, however, there is no known Federal action likely to affect the site where Peter's Mountain Mallow occurs, and no critical habitat is proposed to be designated.

The Act and its implementing regulations found at 50 CFR 17.61, 17.62, and 17.63 set forth a series of general trade prohibitions and exceptions that

apply to all endangered plant species. With certain exceptions, these prohibitions would make it illegal for any person subject to the jurisdiction of the United States to import or export, transport in interstate or foreign commerce in the course of a commercial activity, or sell or offer for sale, this species in interstate or foreign commerce. The Act and 50 CFR 17.62 and 17.63 also provide for the issuance of permits to carry out otherwise prohibited activities involving endangered species under certain circumstances. There is no known commercial trade in *Iliamna corei*, and the Service therefore anticipates few, if any, requests for such permits.

Section 9(a)(2)(B) of the Act, as amended in 1982, prohibits the removal and reduction to possession of endangered plant species from areas under Federal jurisdiction. Permits for exceptions to this prohibition are available through section 10(a) of the Act, until revised regulations are promulgated to incorporate the 1982 Amendments. Proposed regulations implementing this new prohibition were published on July 8, 1983 (48 FR 31417), and it is anticipated that these will be made final following public comment. This prohibition would apply to *Iliamna corei*, although no known populations exist on Federal lands. Requests for copies of the regulations on plants and inquiries regarding them may be addressed to the Federal Wildlife Permit Office, U.S. Fish and Wildlife Service, Washington, D.C. 20240 (703/235–1903).

### Public Comments Solicited

The Service intends that any final rule adopted will be accurate and as effective as possible in the conservation of endangered or threatened species. Therefore, any comments or suggestions from the public, other concerned governmental agencies, the scientific community, industry, or any other interested party concerning any aspect of these proposed rules are hereby solicited. Comments are particularly sought concerning the following:

(1) Biological, commercial trade, or other relevant data concerning any threat (or lack thereof) to *Iliamna corei;*

(2) The location of any additional populations of this species, and the reasons why any habitat should or should not be determined to be critical habitat as provided by section 4 of the Act;

(3) Additional information concerning the taxonomy, range, and distribution of this species; and

(4) Current or planned activities that may affect the existing population.

Final promulgation of a regulation on *Iliamna corei* will take into consideration the comments and any additional information received by the Service, and such communications may lead to a final regulation that differs from this proposal.

The Endangered Species Act provides for a public hearing on this proposal, if one is requested. Such requests must be made in writing and addressed to the Regional Director, U.S. Fish and Wildlife Service, One Gateway Center, Suite 700, Newton, Massachusetts 02158.

### National Environmental Policy Act

The Service has determined that an Environmental Assessment, as defined by the National Environmental Policy Act of 1969, need not be prepared in connection with regulations adopted pursuant to section 4(a) of the Endangered Species Act of 1973, as amended. A notice outlining the Service's reasons for this determination was published in the **Federal Register** on October 25, 1983 (48 FR 49244).

### Literature Cited

Fernald, M.L. 1908. Gray's Manual of Botany, 7th Edition. American Book Company, New York

Kartesz, J.T., and R. Kartesz. 1980. A Synonymized Checklist of the Vascular Flora of the United States, Canada, and Greenland. University of North Carolina Press. Chapel Hill, North Carolina.

Keener, C.S. and J.W. Hardin. 1962. *Iliamna corei* Revisited. Castanea 27:176–178.

Sherff, E.E. 1946. Notes on Certain Plants in the Gray's Manual Range. Rhodora 48:89–96

Sherff, E.E. 1949. Miscellaneous Notes on Dicotyledonous Plants. American Journal of Botany 36:499–511.

Strausbaugh, P.D., and E.L. Core. 1932. *Phymosia remota. Rhodora 34:142–146*

### Author

The author of this proposed rule is Richard W. Dyer, Endangered Species Staff, U.S. Fish and Wildlife Service, One Gateway Center, Suite 700, Newton Corner, Massachusetts 02158 (617/965–5100 or FTS 829–9316).

### List of Subjects in 50 CFR Part 17

Endangered and threatened wildlife, Fish, Marine mammals, Plants (agriculture).

### Proposed Regulation Promulgation

### PART 17—[AMENDED]

Accordingly, it is hereby proposed to amend Part 17, Subchapter B of Chapter I, Title 50 of the Code of Federal Regulations, as set forth below:

1. The authority citation for Part 17 continues to read as follows:

**Authority:** Pub. L. 93–205, 87 Stat. 884; Pub. L. 94–359, 90 Stat. 911; Pub. L. 95–632, 92 Stat. 3751; Pub. L. 96–159, 93 Stat. 1225; Pub. L. 97–304, 96 Stat. 1411 (16 U.S.C. 1531 *et seq.*).

2. It is proposed to amend § 17.12(h) by adding the following, in alphabetical order, under the family Malvaceae, to the List of Endangered and Threatened Plants:

**§ 17.12 Endangered and threatened plants.**

* * * * *

(h) * * *

| Species | | Historic range | Status | When listed | Critical habitat | Special rule |
|---|---|---|---|---|---|---|
| Scientific name | Common name | | | | | |
| Malvaceae—Mallow Family: | | | | | | |
| * * * * * | | | | | | |
| *Iliamna corei* | Peter's Mountain mallow | U.S.A. (VA) | E | | NA | NA |
| * * * * * | | | | | | |

Dated: August 13, 1985.

**P. Daniel Smith,**

*Acting Deputy Assistant Secretary for Fish and Wildlife and Parks.*

[FR Doc. 85–20932 Filed 8–30–85; 8:45 am]

BILLING CODE 4310–55–M

# Notices

Federal Register
Vol. 50, No. 170
Tuesday, September 3, 1985

This section of the FEDERAL REGISTER contains documents other than rules or proposed rules that are applicable to the public. Notices of hearings and investigations, committee meetings, agency decisions and rulings, delegations of authority, filing of petitions and applications and agency statements of organization and functions are examples of documents appearing in this section.

## DEPARTMENT OF AGRICULTURE

### Office of the Secretary

### Review of the United States Sugar Import Quota System

**AGENCY:** Office of the Secretary, USDA.

**ACTION:** Notice.

**SUMMARY:** This notice reviews the U.S. sugar import quota system established by Presidential Proclamation 4941 of May 5, 1982. (47 FR 19661)

**FOR FURTHER INFORMATION CONTACT:** John Nuttall, Chief, Sugar Group, Horticultural and Tropical Products Division, Foreign Agricultural Service, Room 6603, South Building, Department of Agriculture, Washington, D.C. 20250, Telephone: (202) 447-2916.

**SUPPLEMENTARY INFORMATION:**

**I. Introduction**

In accordance with paragraph (f) of Headnote 3, subpart A, part 10, schedule 1 of the Tariff Schedules of the United States (TSUS), the Secretary of Agriculture has consulted with the U.S. Trade Representative, the Department of State, and other concerned agencies on the operation of the sugar import quota system established under the authority of Headnotes 2 and 3 of subpart A of part 10 of schedule 1 of the TSUS, the International Sugar Agreement, 1977, Implementation Act, and Section 201 of the Trade Expansion Act of 1962. After reviewing the operation of the sugar import quota system, the Secretary of Agriculture has determined that the system should be continued in effect in order to give due consideration to the interests in the United States sugar market of domestic producers and materially affected contracting parties to the General Agreement on Tariffs and Trade (GATT). The rationale for this decision is based on the following analysis.

*A. Current World and U.S. Sugar Market Situation*

A fundamental imbalance between world sugar supplies and demand continued during 1984/85. World output of centrifugal sugar in 1984/85 is estimated at 99.4 million metric tons, while consumption is projected at around 95.9 million metric tons. Ending stocks should increase by 3.5 million metric tons to 44.1 million metric tons and will constitute 45 percent of projected consumption, which will have a price depressing effect on world prices. U.S. centrifugal sugar production is estimated at 5.8 million short tons (5.3 million metric tons), and domestic utilization is expected to be 8.17 million short tons (7.41 million metric tons).

During the period October 1, 1984 through July 26, 1985, 1.93 million short tons were charged against the quotas for the 41 countries which have allocations totalling 2,675,000 short tons. The domestic price of raw sugar (c.i.f., duty and free paid, No. 12 contract spot, October 1, 1984 through May 31, 1985, and nearby futures, June 1, 1985 to present, as published by the New York Coffee, Sugar and Cocoa Exchange) averaged 21.05 cents per pound for the first eleven months of the quota year. The world price (f.o.b.s., Caribbean, No. 11 spot contract as published by the New York Coffee, and Cocoa Exchange) has been depressed thrughout the entire 1984/85 quota year, averaging less than 4 cents per pound.

*B. Outlook for World and U.S. Sugar Market*

After the increase in ending stocks in 1984/85, it is likely that world centrifugal sugar production and consumption will be close to balanced in 1985/86. Prospective production declines around the world indicate that the dramatic build-up in stocks of recent years will not be repeated in 1985/86. However, large world sugar stocks will continue to have an extremely depressing effect on prices. This is reflected in world sugar futures prices which currently range from just under 4.5 cents per pound for contracts due in October 1985 to just over 5.5 cents per pound for contracts due to mature in October 1986.

Given these factors, we anticipate that world prices will remain at levels that make it impossible to achieve market conditions that give due consideration to the interests of domestic producers in the U.S. sugar market without a continuation of the current sugar import quota system.

**II. Modification of Sugar Import Quota Year**

Paragraph (d) of Headnote 3, subpart A, Part 10, schedule 1 of the TSUS authorizes the Secretary, after appropriate consultations, to amend the time period for which the quantitative limitations established by paragraph (c) are applicable if he determines that such an amendment is appropriate to give due consideration to the interests in the U.S. sugar market of domestic producers and materially affected contracting parties to the GATT.

Accordingly, on January 11, 1985, after appropriate consultations, the Secretary amended the 1985 sugar import quota year from the period October 1, 1984 through September 30, 1985 to the period October 1, 1984 through November 30, 1985 (50 FR 2303). The amendment was effective on Juanuary 16, 1985 and was designed to give due consideration to the interests in the U.S. sugar market of domestic producers and materially affected contracting parties to the GATT.

**Notice**

In accordance with paragraph (f) of headnote 3, subpart A, part 10, schedule 1 of the TSUS, I have determined that the continued operation of paragraphs (b), (c), (d) and (e) of headnote 3 gives due consideration to the interests in the U.S. sugar market of domestic producers and materially affected contracting parties to the GATT, and that paragraph (g) of that headnote, which would allow entry of sugar into the United States of not to exceed 6.90 million short tons, would not give due consideraitn to such interests.

Signed at Washington, DC, on August 28, 1985.

John R. Norton,

*Acting Secretary of Agriculture.*

[FR Doc. 85-20950 Filed 8-28-85; 4:05 pm]

BILLING CODE 3410-10-M

## Rural Electrification Administration

### Finding of No Significant Impact; Fergus Electric Cooperative, Inc.

**AGENCY:** Rural Electrification Administration, Agriculture.

**ACTION:** Notice of finding of no significant impact.

**SUMMARY:** Notice is hereby given that the Rural Electrification Administration (REA), pursuant to the National Environmental Policy Act of 1969, as amended, the Council on Environmental Quality Regulations (40 CFR Part 1500), and REA Environmental Policies and Procedures, 7 CFR Part 1794, has made a Finding of No Significant Impact (FONSI) with respect to a project proposed by Fergus Electric Cooperative, Inc. (Fergus Electric), of Lewistown, Montana. The project consists of constructing approximately 72 km (45 miles) of 69 kV transmission line. The line will be located in Fergus County, Montana.

**FOR FURTHER INFORMATION CONTACT:** REA's FONSI and Environmental Assessment (EA) may be reviewed at or obtained from the office of the Acting Director, Western Area—Electric, REA, Room Number 0207, 14th St. and Independence Avenue, SW., Washington, D.C. 20250, telephone number: (202) 382–8848, or the office of Fergus Electric Cooperative, Inc. (Mr. Richard Peck, Manager), P.O. Box 4040, Lewistown, Montana 59457, telephone number: (406) 538–3465, during regular business hours.

**SUPPLEMENTARY INFORMATION:** REA reviewed the Borrower's Environmental Report (BER) submitted by Fergus Electric and determined that it represents an accurate assessment of the environmental impact of the proposed project.

The proposed project consists of constructing approximately 72 km (45 miles) of 69 kV transmission line between Glengarry and Grass Range in Fergus County, Montana. Possible REA actions could include providing financing assistance to Fergus Electric for the proposed project and approving construction contracts, power supply contracts, etc., related to utilization of the proposed facilities.

The BER and EA adequately consider potential impacts of the proposed project to resources including threatened and endangered species, prime farmland, prime forest land, prime rangeland, cultural resources, floodplains, and wetlands.

Alternatives examined included no action, energy conservation, rebuilding the existing power line, alternative routes for transmission line construction, and underground construction. After reviewing these alternatives, REA determined that the proposed project is an acceptable alternative that meets Fergus Electric's needs with a minimum of environmental impact.

In accordance with REA's Environmental Policies and Procedures, 7 CFR Part 1794, Fergus Electric advertised the availability of its BER in the local newspaper. No comments were received.

Based upon the BER and other data, REA prepared an EA and FONSI concerning the proposed construction. REA independently evaluated the proposed project and concluded that approval of financing assistance for the project would not constitute a major Federal action significantly affecting the quality of the human environment.

This program is listed in the Catalog of Federal Domestic Assistance as 10.850—Rural Electrification Loans and Loan Guarantees.

Dated: August 23, 1985.

**Harold V. Hunter,**

*Administrator.*

[FR Doc. 85–20911 Filed 8–30–85; 8:45 am]

BILLING CODE 3410–15–M

## COMMISSION ON CIVIL RIGHTS

### Arizona Advisory Committee; Agenda for Public Meeting

Notice is hereby given, pursuant to the provisions of the Rules and Regulations of the U.S. Commission on Civil Rights, that a meeting of the Arizona Advisory Committee to the Commission will convene at 1:00 p.m. and adjourn at 5:00 p.m. on September 27, 1985, at the Embassy Suites, 3211 East Pinchot Street, Aztec Room, Phoenix Arizona. The purpose of the meeting is to discuss proposed plans for projects involving Yuma schools and the Arizona National Guard.

Persons desiring additional information, or planning a presentation to the Committee, should contact Committee Chairperson, John P. White, or Philip Montez, Director of the Western Regional Office at (213) 688–3437, (TDD 213/894–0508).

The meeting will be conducted pursuant to the provisions of the Rules and Regulations of the Commission.

Dated at Washington, D.C., August 27, 1985.

**Bert Silver,**

*Assistant Staff Director for Regional Programs.*

[FR Doc. 85–20917 Filed 8–30–85; 8:45 am]

BILLING CODE 6335–01–M

### California Advisory Committee; Agenda and Public Meeting

Notice is hereby given, pursuant to the provisions of the Rules and Regulations of the U.S. Commission on Civil Rights, that a meeting of the California Advisory Committee to the Commission will convene at 3:00 p.m. and adjourn at 6:00 p.m. on September 20, 1985, at the Western Regional Office, 3660 Wilshire Blvd., Suite 810, Los Angeles California. The purpose of the meeting is to discuss proposed plans for future projects.

Persons desiring additional information, or planning a presentation to the Committee, should contact Committee Chairperson Maxwell Greenberg of Philip Montez, Director of the Western Regional Office, at (213) 688–34378, (TDD 213.894–3031).

The meeting will be conducted pursuant to the provisions of the Rules and Regulations of the Commission.

Dated at Washington, D.C., August 27, 1985.

**Bert Silver,**

*Assistant Staff Director for Regional Programs.*

[FR Doc. 85–20918 Filed 8–30–85; 8:45 am]

BILLING CODE 6335–01–M

### Delaware Advisory Committee; Agenda and Public Meeting

Notice is hereby given, pursuant to the provisions of the Rules and Regulations of the U.S. Commission on Civil Rights, that a meeting of the Delaware Advisory Committee to the Commission will convene at 1:30 p.m. and adjourn at 4:00 p.m. on September 24, 1985, at the Boggs Federal Courthouse, 844 King Street, Conference Room #3207, Wilmington, Delaware. The purpose of the meeting is to discuss a draft of the Status of Civil Rights Report and possible new project(s) for the Program Year 1985–86.

Persons desiring additional information, or planning a presentation to the Committee, should contact Committee Chairperson, William J. Conner, or John I. Binkley, Director of the Mid-Atlantic Regional Office at (202) 254–6717, (TDD 202/254–5461).

The meeting will be conducted pursuant to the provisions of the rules and regulations of the Commission.

Dated at Washington, D.C., August 27, 1985.

**Bert Silver,**

*Assistant Staff Director for Regional Programs.*

[FR Doc. 85-20916 Filed 8-30-85; 8:45 am]

BILLING CODE 6335-01-M

## DEPARTMENT OF COMMERCE

### National Oceanic and Atmospheric Administration

### Change in the Construction Setback Line in the Town of Gulf Shores, AL as Amendment to the Alabama Coastal Area Management Program Under the Coastal Zone Management Act

**AGENCY:** National Oceanic and Atmospheric Administration, National Ocean Service, Office of Ocean and Coastal Resource Management.

**ACTION:** Notice of Approval of Amendment.

**SUMMARY:** Notice is hereby given that on August 27, 1985, the Director of the Office of Ocean and Coastal Resource Management, National Ocean Service, National Oceanic and Atmospheric Administration (NOAA) approved Amendment No. 1 to the federally-approved Alabama Coastal Area Management Program (ACAMP). The change consists of the reduction of the Construction Setback Line (CSL) for the Business, Tourist and Lodging (BTL) and the Business, Central Resort (BCR) zones as defined on July 16, 1984 by the zoning maps of the Town of Gulf Shores to five (5) feet instead of forty (40) feet behind the most inland point of the crestline of the primary dune system. This approval was made pursuant to Section 306 of the Coastal Zone Management Act of 1972 (CZMA), as amended (16 U.S.C. 1451 *et. seq.*), and NOAA regulations on Amendments to Approved State Management Programs, 15 CFR 923.80-923.82 (March 28, 1979).

Notice of the Director's preliminary decision to approve the amendment was published on June 25, 1985 in the **Federal Register**. A 30-day comment period was provided, and two responses were received which supported approval or provided no objection. A copy of the findings made by the Director that this Amendment meets the requirements of the CZMA may be obtained from the Office of Ocean and Coastal Resource Management. Inquiries regarding the ACAMP and the findings should be addressed to:

James P. Burgess, Acting Chief, Coastal Programs Division, Page Building No. 1, 3300 Whitehaven Street, NW., Washington, D.C. 20235, (202) 634-1672

In accordance with Section 307 of the CZMA, Federal agencies are required to conduct their activities in the coastal zone consistent to the maximum extent practicable with the ACAMP, as amended. The Federal consistency requirements are fully explained at 15 CFR Part 930 (June 25, 1979). To determine how these requirements are applied in Alabama, Federal agencies should contact William A. Rushton, Director, Office of State Planning and Federal Programs, State Capitol, Montgomery, AL 36130, (205) 284-8706.

(Federal Domestic Assistance Catalog 11.419 Coastal Zone Management Program Administration)

Dated: August 27, 1985.

**James P. Blizzard,**

*Acting Director, Office of Ocean and Coastal Resource Management.*

[FR Doc. 85-20882 Filed 8-30-85; 8:45 am]

BILLING CODE 3510-08-M

**[Modification No. 1 to Permit No. 292]**

### Marine Mammals; Permit Modification; Richard S. Borguss

Notice is hereby given that pursuant to the provisions of § 216.33(d) and (e) of the Regulations governing the Taking and Importing of Marine Mammals (5) CFR Part 216), Public Display Permit No. 292 issued to Mr. Richard Scott Borguss, P.O. Box 2114, Key Largo, Florida 33037, on June 3, 1980 (45 FR 38432), is modified by adding the following:

Section B.7

7. The Holder is authorized to have a human/ dolphin diving program as described in the modification. This modification is subject to periodic review by the Assistant Administrator for Fisheries and can be revoked at any time.

Section B.8

8. The Holder shall submit a quarterly report, reporting number of human/dolphin dives, any behavioral modifications of the animals, and any health related problems. This report should be submitted to the Assistant Administrator for fisheries, National Marine Fisheries Service, Department of Commerce, Washington, D.C. 20235.

This modification became effective on August 23, 1985.

The permit as modified and documentation pertaining to the modification are available for review in the following offices:

Assistant Administrator for Fisheries, National Marine Fisheries Service, 3300 Whitehaven Street, NW., Washington, D.C.; and

Regional Director, Southeast Region, National Marine Fisheries Service, 9450 Koger Boulevard, St. Petersburg, Florida 33702.

Dated: August 26, 1985.

**James E. Douglas, Jr.**

*Deputy Assistant Administrator for Fisheries.*

[FR Doc. 85-20775 Filed 8-30-85; 8:45 pm]

BILLING CODE 3510-22-M

### National Technical Information Service

### Calcol, Inc.; Intent To Grant Exclusive Patent License

The National Technical Information Service, (NTIS), U.S. Department of Commerce, intends to grant to Calcol, Inc., having a place of business in Shaker Heights, Ohio an exclusive right to manufacture, use, and sell products embodied in the inventions entitled "Compound, 4-Carboxyphthalato (1,2-Diaminocyclohexane) Platinum (II) and Alkali Metal Salts Thereof," U.S. Patent No. 4,137,248 and "7-0-(2,6-dideoxy-α-1-lyxo-hexopyranosyl)-daunomycinone, desmethoxy daunomycinone, adriamycinone, and carminomycinone," U.S. Patent No. 4,201,773. The patent rights in these inventions have been assigned to the United States of America, as represented by the Secretary of Commerce.

The proposed exclusive licenses will be royalty-bearing and will comply with the terms and conditions of 35 U.S.C. 209 and 37 CFR 404. The proposed licenses may be granted unless, within sixty days from the date of this published Notice, NTIS receives written evidence and argument which establishes that the grant of the proposed licenses would not serve the public interest.

Inquiries, comments and other materials relating to the proposed licenses may be submitted to the Office of Federal Patent Licensing, NTIS, Box 1423, Springfield, VA 22151.

**Douglas J. Campion,**

*Office of Federal Patent Licensing, U.S. Department of Commerce, National Technical Information Service.*

[FR Doc. 85-20957 Filed 8-30-85; 8:45 am]

BILLING CODE 3510-04-M

## COMMODITY FUTURES TRADING COMMISSION

### Chicago Board of Trade; European Currency Unit Futures Contract

**AGENCY:** Commodity Futures Trading Commission.

**ACTION:** Notice of availability of the terms and conditions of proposed commodity futures contract.

**SUMMARY:** The Chicago Board of Trade ("CBT") has applied for designation as a contract market in European Currency Units. The Commodity Futures Trading Commission ("Commission") has determined that the terms and conditions of the proposed futures contract are of major economic significance and that, accordingly, making available the proposed contract for public inspection and comment is in the public interest, will assist the Commission in considering the views of interested persons, and is consistent with the purposes of the Commodity Exchange Act.

**DATE:** Comments must be received on or before November 4, 1985.

**ADDRESS:** Interested persons should submit their views and comments to Jean A. Webb, Secretary, Commodity Futures Trading Commission, 2033 K Street NW., Washington, D.C. 20581. Reference should be made to the CBT European Currency Unit futures contract.

**FOR FURTHER INFORMATION CONTACT:** Naomi Jaffe, Division of Economic Analysis, Commodity Futures Trading Commission, 2033 K Street NW., Washington, D.C. 20581 (202) 254–7227.

A copy of the terms and conditions of the proposed CBT European Currency Unit futures contract will be available for inspection at the Office of the Secretariat, Commodity Futures Trading Commission, 2033 K Street, NW., Washington, D.C. 20581. Copies of the terms and conditions can be obtained through the Office of the Secretariat by mail at the above address or by phone at (202) 254–6314.

Other materials submitted by the CBT in support of its application for contract market designation may be available upon request pursuant to the Freedom of Information Act (5 U.S.C. 552) and the Commission's regulations thereunder (17 CFR Part 145 (1984)), except to the extent that they are entitled to confidential treatment as set forth in 17 CFR 145.5 and 145.9. Requests for copies of such materials should be made to the FOI, Privacy and Sunshine Acts Compliance Staff of the Office of the Secretariat at the Commission's headquarters in accordance with 17 CFR 145.7 and 145.8.

Any person interested in submitting written data, views or arguments on the terms and conditions of the proposed futures contract, or with respect to other materials submitted by the CBT in support of its application, should send such comments to Jean A. Webb, Secretary, Commodity Futures Trading Commission, 2033 K Street NW., Washington, D.C. 20581, by November 4, 1985.

Issued in Washington, D.C., on August 28, 1985.

**Jean A. Webb,**

*Secretary to the Commission.*

[FR Doc. 85–20959 Filed 8–30–85; 8:45 am]

BILLING CODE 6351-01-M

## DEPARTMENT OF EDUCATION

### Intergovernmental Advisory Council on Education; Meeting

**AGENCY:** Intergovernmental Advisory Council on Education, Education.

**ACTION:** Notice of meeting.

**SUMMARY:** This notice sets forth the schedule and proposed agenda of a meeting of the Intergovernmental Advisory Council on Education. Notice of this meeting is required under Section 10(a)(2) of the Federal Advisory Committee Act.

**DATE:** September 30, 1985.

**ADDRESS:** Department of Education, 400 Maryland Avenue SW., Room 3000, Washington, D.C. 20202.

**FOR FURTHER INFORMATION CONTACT:** Jacqueline McGregor, Executive Director, Intergovernmental Advisory Council on Education, Department of Education, 300 7th Street SW., Washington, D.C. 20202 (202) 472–6464.

**SUPPLEMENTARY INFORMATION:** The Intergovernmental Advisory Council on Education was established under section 213 of the Department of Education Organization Act (20 U.S.C. 3423). The Council is established to provide assistance and make recommendations to the Secretary and the President concerning intergovernmental policies and relations pertaining to education.

The meeting of the Council is open to the public. The meeting is scheduled for 1 p.m. to 4 p.m. on September 30.

The proposed agenda includes:

—Upcoming Conference on Job Training and Retraining
—General Education Provisions Act (GEPA)
—Followup on National Networking Conference
—Adoption of Council Bylaws
—Election of Executive Committee

Records are kept of all Council proceedings and are available for public inspection at the office of the Intergovernmental Advisory Council on Education, 300 7th Street SW., Room 513, Washington, D.C.

Signed at Washington, D.C. on Friday, August 23, 1985.

**A. Wayne Roberts,**

*Deputy Under Secretary for Intergovernmental and Interagency Affairs.*

[FR Doc. 85–20906 Filed 8–30–85; 8:45 am]

BILLING CODE 4000-01-M

### National Advisory and Coordinating Council on Bilingual Education; Meeting

**AGENCY:** Department of Education.

**ACTION:** Notice of meeting.

**SUMMARY:** This notice sets forth the schedule and proposed agenda of a forthcoming meeting of the National Advisory and Coordinating Council on Bilingual Education. Notice of this meeting is required under section 10(a)(2) of the Federal Advisory Committee Act. This document is intended to notify the general public of their opportunity to attend.

**DATES:** September 25, 1985—Orientation session for NACCBE members from 9:00 a.m.–4:30 p.m. September 26–27, 1985 Business Meeting 9:00 a.m. to 4:30 p.m. The orientation and business meeting will be held at: The orientation and business meeting will be held at: The U.S. Department of Education, Federal Office Building Number (6), Room 5026, 400 Maryland Avenue SW., Washington, D.C. 20202.

**FOR FURTHER INFORMATION CONTACT:** Paul Balach, Designated Federal Official, Office of Bilingual Education and Minority Languages Affairs, Reporter's Building, Room 421, 400 Maryland Avenue, SW., Washington, D.C. 20202, (202) 245–2600.

**SUPPLEMENTARY INFORMATION:** The National Advisory and Coordinating Council on Bilingual Education is established under section 752(a) of the Bilingual Education Act (20 U.S.C. 3262). NACCBE is established to advise the Secretary of the Department of Education concerning matters arising in the administration of the Bilingual Education Act and other laws affecting the education of limited English proficient populations. The meeting of the Council is open to the public. The proposed agenda includes the following:

I. Call to Order
II. Roll Call
III. Approval of Minutes from Previous Meeting
IV. Introduction of Visitors
V. Presentation of Information by Director of OBEMLA or Designee

VI. Presentation of Information by General Public or Organizations (Limited to 5 minutes)
VII. Committee Assignments
VIII. Old Business
IX. New Business
X. Presentations of Information by Members of the General Public on Items for Possible Future Action by the Council
XI. Meetings of Council Committees
XII. Council reconvenes
XIII. Adjournment

Records are kept of all Council proceedings and are available for public inspection at the Office of Bilingual Education and Minority Languages Affairs, Reporter's Building, Room 421, 400 Maryland Avenue, SW., Washington, D.C. 20202, Monday through Friday from 8:00 a.m.–4:30 p.m.

Dated: August 29, 1985.

**Carol Pendas Whitten,**

*Director, Office of Bilingual Education and Minority Languages Affairs.*

[FR Doc. 85–20972 Filed 8–30–85; 8:45 am]

BILLING CODE 4000-01-M

## DEPARTMENT OF ENERGY

### Economic Regulatory Administration

### Final Consent Order With Oxy Petroleum, Inc.

**AGENCY:** Economic Regulatory Administration, DOE.

**ACTION:** Final action on proposed consent order.

**SUMMARY:** The Economic Regulatory Administration (ERA) has determined that a proposed Consent Order between the Department of Energy (DOE) and Oxy Petroleum, Inc., (Oxy) shall be made a final order of the DOE. The Consent Order resolves all claims by DOE asserted in a Notice of Probable Violation (NOPV) relating to Oxy's compliance with the federal petroleum price and allocation regulations for the period September 1973 through January 31, 1976. Oxy will pay to the DOE $2,717,320.75. The monies would be deposited in a suitable account pending distribution by DOE. The decision to make the Oxy Consent Order final as modified was made after a review of all written comments received.

The final Consent Order incorporates the following modifications:

(1) Inclusion of a record-keeping requirement that conforms to 10 CFR 210.1, ensuring the availability of data necessary to the completion of refund procedures; and

(2) Inclusion of a provision that makes clear that the Consent Order does not affect suits involving other crude oil property operators. Other modifications were made to the provisions regarding the release of sensitive commercial and financial information and DOE's reservation of a right to seek remedies for newly discovered regulatory violations.

The Consent Order as modified is effective as a final order of the DOE on the date the document was executed.

**FOR FURTHER INFORMATION CONTACT:** Meyer Magence, Office of Special Counsel (RG–13), Economic Regulatory Administration, 1000 Independence Avenue, S.W., Washington, D.C. 20585, (202) 252–4945.

**SUPPLEMENTARY INFORMATION:**



### I. Introduction

ERA issued a notice announcing a proposed consent order between DOE and Oxy which would resolve matters raised by an NOPV issued by the DOE relating to Oxy's compliance with the federal petroleum price and allocation regulations for the period September 1973 through January 31, 1976. 46 FR 50304 (December 27, 1984). The proposed consent order requires to pay $2,717,320.75 for the settlement of alleged overcharges and interest. The notice solicited written comments from the public relating to the terms and conditions of the settlement.

### II. Comments Received

ERA received four comments, which addressed the question of the ultimate disposition of the funds to be paid by Oxy pursuant to the settlement, but did not question the basis of the settlement or the adequacy of the settlement amount. Comments were received from the following:

Attorney General of Texas
Controller, State of California
State of Indiana
Attorneys General of Arkansas, Delaware, Iowa, Kansas, Louisiana, North Dakota, Rhode Island, and West Virginia.

The comments received did not relate to the issue of whether the Consent Order should be modified, rejected or adopted as a final order. The Attorney General of Texas stated that, since ERA did not identify any injured persons, ERA should request the implementation of Subpart V proceedings. The State of Indiana, on the other hand, argued for disbursal of the monies to the states. Attorneys General from a number of states asserted that the monies shoud be paid to the states after refunds have been made to parties claiming actual injury. The Controller of the State of California indicated a preference for a specific reference in the Consent Order to Subpart V proceedings or payments to the states.

During the period covered by this Consent Order the violations allegedly committed by Oxy related to the miscertification of its crude oil. Such violations resulted in cost increases that were disseminated to all refiners by the entitlements program, who could then pass the overcharges on to others. *See United States* v. *Exxon Corp*, —F.2d—, Slip op. at 110–112 (TECA, July 1, 1985) (Nos. 91 *et seq.*).

The DOE's Office of Hearings and Appeals in a report to the District Court for the District of Kansas in *In re: The Department of Energy Stripper Well Litigation*, MDL No. 378, determined that where alleged crude oil violations involve such crude oil miscertifications, the resulting harm cannot be traced to specific customers. As explained by the DOE in an accompanying Statement of Restitutionary Policy:

> Essentially, OHA concluded that direct purchasers (as such) generally did not absorb the overcharges because they were reimbursed by the entitlements programs. Tracing of overcharges is impossible in view of the spreading effects of the entitlements program, the fungibility of refiner costs and the consequent ability of firms and OHA to determine which costs were passed through and which, if any, were retained, and the high proportion of cost passthrough, among other factors.
>
> OHA's finding that it is impossible to trace crude oil cost increases that were equalized by the entitlements program, . . . is consistent with the conclusions of two district courts that have previously determined that the harm resulting from crude oil miscertifications cannot be traced. *Id.*

DOE then examined the possible use of econometric modeling methods to estimate the extent to which overcharges were passed through at the various distribution levels within the industry. With regard to this indirect methodology, DOE concluded:

> It is too inexact in determining injury to particular classes of claimants and yields no conclusions concerning the injury to individuals within any class. The governmental costs in resources and, more importantly, societal costs in years of continued litigation prior to distribution are unacceptably high. *Id.* at 27402.

Subpart V contemplates proceedings to identify injured persons (10 CFR 205.280). When it is impossible to determine which persons were ultimately injured, as in violations involving crude oil miscertifications,

such proceedings are futile and, therefore, not appropriate. Accordingly, the funds received from Oxy pursuant to the Consent Order will not be the subject of a Subpart V petition and proceeding.

DOE's Statement of Policy also addressed the question of how to effect indirect restitution where refunds to individual claimants are infeasible. The policy statement provides that the ERA will retain the monies received in an escrow account for a reasonable time to allow Congress an opportunity to determine an appropriate disposition of the funds. If Congress does not enact legislation within a reasonable time, the DOE will transfer the funds to the general fund of the U.S. Treasury. The Policy Statement explains that this is preferable to further *ad hoc* payments to the states because:

> [T]he states, as a result of the decisions in *Exxon* and *Sutton*, will receive more than two billion dollars for use in certain federally-established energy programs. The Department of Energy, which is responsible for administering and overseeing most of these programs at the federal level, has concluded that the states cannot make effective use of additional monies (beyond those appropriated by Congress and awarded by the *Exxon* and *Sutton* courts) for these programs at this time. *supra*, at 27402.

Because the terms of the settlement are consistent with the foregoing action, ERA has determined to proceed with the finalization of the Consent Order.

### III. Modifications to the Consent Order

The ERA is seeking to standardize its Consent Orders as much as possible and has modified the Oxy Consent Order pursuant to that goal. A matter of particular concern to the DOE is the need for the firm to retain records for possible future use by the DOE in the disbursement of settlement monies.

Pursuant to the preamble to the ERA's recent revision of its regulation, 50 FR 4957, 4960 (February 5, 1985), firms with restitutionary payments subject to distribution must be required to maintain records to permit appropriate distribution of these payments. Accordingly, ERA and Oxy have agreed to modify the proposed Consent Order.

Another modification makes clear that the Consent Order does not affect any action DOE may bring against a third-party crude oil property operator nor does the Consent Order afford Oxy any protection from any possible suit against it for contribution by such a third-party operator.

Because the above-mentioned modifications to the Consent Order do not affect the basic settlement amount or substantially alter the basis of the settlement, DOE has determined that the modifications do not require an opportunity to file additional comments.

### IV. Decision

Pursuant to 10 CFR 205.199J, the Consent Order between Oxy and DOE as modified was made a final order of the DOE on August 5, 1985, the date the modified Consent Order was executed.

Issued in Washington, DC, on August 22, 1985.

**Milton C. Lorenz,**

*Special Counsel, Economic Regulatory Administration.*

[FR Doc. 85-20977 Filed 8-30-85; 8:45 am]

BILLING CODE 6450-01-M

## Proposed Consent Order With Marathon Petroleum Co.

*Correction*

In FR Doc. 85-20583 beginning on page 34901 in the issue of Wednesday, August 28, 1985, make the following correction: In the second column, second complete paragraph, third line, "September 30, 1985" should read "September 27, 1985".

BILLING CODE 1505-01-M

## Federal Energy Regulatory Commission

**[Docket No. CI85-244, et al.]**

## Notice of Quarterly Status Conferences and Cancellation of a Conference; Arkoma Production Co., et al.

August 27, 1985.

Listed below are quarterly status conferences to be held pursuant to Commission order of September 28, 1985, to evaluate whether the implementation of the special marketing program in each proceeding is achieving the Commission's purposes. The conferences shall be held at the offices of the Commission at 825 North Capitol Street, N.E., Washington, D.C. All interested persons and Staff are invited to attend.

| Date | Time | Company | Docket No. |
|---|---|---|---|
| Sept. 18, 1985 | 10:00 a.m. | Arkoma Production Company | CI85-244 |
| | 2:00 p.m. | Samson Resources, Inc | CI85-239 |
| Sept. 19, 1985 | 10:00 a.m. | Walter Oil & Gas Corporation | CI85-424 |
| | 2:00 p.m. | Panhandle Eastern Pipe Line Co./Trunkline Gas Company. | CP83-333 |
| Sept. 20, 1985 | 10:00 a.m. | Cities Service Oil & Gas Company | CI84-485 |
| | 2:00 p.m. | Yankee Resources | CI84-565 |
| Sept. 23, 1985 | 2:00 p.m. | Tennessee Gas Pipe Line Company | CP83-502 |
| Sept. 24, 1985 | 10:00 a.m. | Columbia Gas Transmission Company | CP83-452 |
| | 2:00 p.m. | TXP Operating Company | CI84-374 |
| Sept. 25, 1985 | 10:00 a.m. | Tenneco Oil Company, Inc. | CI83-269 |
| | 2:00 p.m. | Citizens Energy Corporation/Citizens Resources Corporation. | CI84-255 |
| Sept. 27, 1985 | 10:00 a.m. | Union Texas Petroleum Company | CI85-99 |
| | 2:00 p.m. | Kerr McGee Corporation | CI85-176 |
| Sept. 30, 1985 | 2:00 p.m. | Texas Gas Exploration | CI85-36 |

The quarterly meeting scheduled for September 24, 1985, for Amoco Production Company (Docket No. CI84-485) has been cancelled. Amoco's Special Marketing Program (ASMP) was terminated pursuant to the Company's request of June 18, 1985, and the Commission's order issued July 15, 1985, approving the request.

**Kenneth F. Plumb,**

*Secretary.*

[FR Doc. 85-20913 Filed 8-30-85; 8:45 am]

BILLING CODE 6717-01-M

**[Docket No. SA85-40-000]**

## Petition for Adjustment and Waiver of Filing Fee; Dawson Operating Co., Inc.

August 27, 1985.

On June 14, 1985, Dawson Operating Co., Inc. (Dawson) filed with the Federal Energy Regulatory Commission, a petition for an adjustment pursuant to section 502(c) of the Natural Gas Policy Act of 1978 (NGPA) (15 U.S.C. 3301, *et seq.*), and Part 385, Subpart K of the Commission's regulations. Dawson seeks adjustment under Subpart H of Part 271 of the Commission's regulations.

The petition and additional information indicate Dawson received a final determination in 1980 that the Roetker No. 2 Well in Harper County, Oklahoma, qualified as a stripper gas well. In 1981, Northern Natural Gas Company (Northern), purchaser from the well, filed a notice of disqualification with the Commission based on production of the well during the latter part of 1980 which exceeded stripper gas well limits. On September 14, 1981, Dawson filed a petition for enhanced recovery status with the Oklahoma Corporation Commission. The petition was denied based on the well's disqualification and lack of requalification prior to the enhanced recovery work performed in March of

1981. Data contained in the enhanced recovery filing indicates that had Dawson filed an application for a new NGPA section 108 determination subsequent to the disqualification, the well, based on sales to Northern, could have requalified as of the end of December, 1980. Dawson also states that it would not be able to make refunds to Northern if its petition were denied.

Dawson requests an adjustment under Subpart H of Part 271 of the Commission's regulations allowing it opportunity to seek or re-establish qualification of the well as a stripper gas well for a period prior to its enhanced recovery work, so that it may seek reconsideration of its enhanced recovery petition.

In addition, Dawson requests a waiver of the applicable filing fee, pursuant to 18 CFR 381.106.

The procedures applicable to the conduct of this adjustment proceeding are found in Subpart K of the Commission's Rules of Practice and Procedure. Any person desiring to participate in this adjustment proceeding must file a motion to intervene in accordance with the provisions of Subpart K. All motions to intervene must be filed within 15 days after publication of this notice in the **Federal Register.**

**Kenneth F. Plumb,**

*Secretary.*

[FR Doc. 85-20914 Filed 8-30-85; 8:45 am]

BILLING CODE 6717-01-M

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**[Docket No. TA85-3-56-000, 001]**

## Change in Rates Pursuant to Purchased Gas Cost Adjustment Provisions; Valero Interstate Transmission Co.

August 26, 1985.

Take notice that on August 16, 1985, Valero Interstate Transmission Company ("Vitco") tendered the following tariff sheets for filing in an out-of-cycle PGA containing changes in rates pursuant to purchased gas cost adjustment provisions:

Ninth Revised Sheet No. 14, To FERC Gas Tariff, Original Volume No. 1.
Original Sheet No. 14.1, To FERC Gas Tariff, Original Volume No. 1.
Third Revised Sheet No. 6, To FERC Gas Tariff, Original Volume No. 2.

The changes proposed in the filing consist of:

(1) A PGA decrease of $.0047 per Mcf in Vitco's rate for service under Rate Schedule T-1;

(2) A rate for new service under Rate Schedule SS-1 of $2.64 per MMBtu;

(3) A PGA decrease of $.6076 per Mcf in Vitco's rate for service under Rate Schedule S-3; and

(4) A surcharge equivalent to $.1058 per Mcf under Rate Schedule S-3.

The PGA changes and the rate for service under Rate Schedule SS-1 are based on gas costs under limited term sales programs approved by the Commission in its August 2, 1985, order approving the Stipulation And Agreement filed June 12, 1985, in certain dockets [1], as amended. The surcharge under Rate Schedule No. S-3 is designed to eliminate the balance in the deferred purchased gas cost account for that rate schedule.

The proposed effective date for the above filing is August 19, 1985, coincident with the implementation by Vitco of the authorizations granted by the Commission in its order approving the Stipulation and Agreement. Vitco requests that the Commission waive any order or regulations as the Commission may deem necessary to accept the above tariff sheets to be effective August 19, 1985.

Any person desiring to be heard or to protest said filing should file a motion to intervene or protest with the Federal Energy Regulatory Commission, 825 North Capitol Street, NE., Washington, D.C. 20426, in accordance with the Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 384.211 and 385.214). All such motions or protests should be filed on or before September 3, 1985. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection.

**Kenneth F. Plumb,**

*Secretary.*

[FR Doc. 85-20915 Filed 8-30-85; 8:45 am]

BILLING CODE 6717-01-M

[1] *Transcontinental Gas Pipe Line Corporation*, Docket Nos. CP84-183-000, CP84-183-001; *Valero Interstate Transmission Company*, Docket No. CP85-186-000; *Shell Western E&P Inc.*, Docket Nos. CI85-206-000, CI85-207-000, and CI85-213-000.

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**[Docket No. CI85-633-000]**

## Tenneco Oil Co., et al.; Application for Blanket Certificate of Public Convenience and Necessity and for an Order Permitting and Approving Abandonment and Pre-Granted Abandonment

August 27, 1985.

Take notice that on August 20, 1985, Tenneco Oil Company, Houston Oil and Minerals Corporation, Tenneco Exploration, Ltd., Tenneco Exploration II, Ltd., TINCO, Ltd., and Tenneco West, Inc. (hereinafter referred to collectively as Tenneco Oil) filed an application pursuant to sections 4 and 7 of the Natural Gas Act (NGA), and the provisions of 18 CFR Parts 154, 157, and 385 seeking a blanket certificate of public convenience and necessity (1) authorizing the sale for resale in interstate commerce of certain natural gas produced by Tenneco Oil and its joint interest owners, (2) authorizing blanket temporary abandonment and pre-granted permanent abandonment of certain sales as described therein, and (3) authorizing transportation by interstate pipelines (and the pre-granted abandonment of same), where and if necessary, to effectuate the sale and purchase of gas on the spot market, as more fully described in the Application which is on file with the Commission and open for public inspection. The Applicants also request that said blanket authorization be made effective on or before November 1, 1985.

Tenneco Oil states that its considerable experience in the spot market to date demonstrates that the blanket authority as requested is consistent with the Commission's rules and regulations, *i.e.*, Parts 154 and 157 requirements, and is necessary to be compatible with the spot market. Further, Tenneco Oil states that, absent said blanket authorization, the flexibility and efficiency necessary for successful operation of the spot market would be hindered. Tenneco Oil intends to enter into blanket sales and transportation agreements in order to improve effective management of these spot market arrangements, and to facilitate more efficient and cost-effective transportation.

Tenneco Oil emphasizes that no Commission-mandated scheme of contract carriage or market access is sought by its Application. A decision by an interstate pipeline, intrastate pipeline

or local distribution company to have gas transported on its behalf, or to provide transportation services as a participating pipeline, or for pipelines to enter into blanket transportation agreements with Tenneco Oil, is purely voluntary. Rather, Tenneco Oil is seeking to further the efficient operation of the spot market.

Specifically, Tenneco Oil requests that the Commission authorize Tenneco Oil, effective on or before November 1, 1985:

(1) To make sales for resale in interstate commerce, without supply or market limitations, of NGA-gas with an applicable maximum lawful ceiling price higher than the Natural Gas Policy Act (NGPA) section 109 ceiling price that is produced from various interests owned by Tenneco Oil;

(2) To make sales for resale in interstate commerce, without supply or market limitations, of NGA-gas with an applicable maximum lawful ceiling price higher than the NGPA Section 109 price and produced from various interests attributable to other owners having interests in the same wells as Tenneco Oil, to the extent that such joint interest owners agree to same;

(3) To abandon, temporarily, sales for resale of NGA-gas with an applicable maximum lawful ceiling price higher than the NGPA Section 109 price and previously certificated by the Commission, to the extent that such gas is released by interstate pipelines for resale in the spot market to third parties;

(4) To abandon (pre-granted abandonment) any sale for resale in the spot market authorized pursuant to any blanket certificate issued herein; and

(5) To have both NGA- and non-NGA-gas that is sold in the spot market by Tenneco Oil and its joint interest owners transported in interstate commerce, on a self-implementing basis and without source or recipient limitations, by any willing transporter to any willing and able purchaser of such gas, with pre-granted abandonment of same.

Tenneco Oil is requesting the authorization described herein only to the extent that any element of such authorization is not otherwise made effective on or before November 1, 1985, as a result of Commission action in any other proceeding. In particular, Tenneco Oil references the Commission's Notice of Proposed Rulemaking (NOPR) issued May 30, 1985, in Docket No. RM85-1-000 and states that the blanket authority requested would be supplemental to the flexible transportation scheme proposed by the NOPR and would be necessary to achieve the NOPR objectives.

Sales proposed to be made by Tenneco Oil on behalf of itself and its joint interest owners will not involve a dedication of reserves but will be based on periodic nominations, either by purchasers or by Tenneco Oil. The sales volumes, prices, purchasers, delivery points, transporter, and supply source will vary. Although sales made by Tenneco Oil to end-users would qualify as direct sales, and thus not require a sales certificate, other sales under the blanket authority requested will be for resale and will vary on a periodic basis, depending on the nominations. Tenneco Oil proposes to sell and deliver to various spot gas purchasers all or a portion of the gas Tenneco Oil determines is available for sale at the most favorable terms for Tenneco Oil for a particular month. Tenneco Oil will not be obligated to sell gas pursuant to any nomination or proposed nomination until the exact volumes, terms and conditions, and prices are agreed to by Tenneco Oil and a purchaser. The actual contract between Tenneco Oil and the spot gas purchaser may be for all or any portion of the quantity which was set out in the nomination or proposed nomination.

Any person desiring to be heard or to make any protest with reference to said Application should, on or before September 10, 1985, file with the Federal Energy Regulatory Commission, Washington, D.C. 20426, a motion to intervene or a protest in accordance with the requirements of the Commission's Rules of Practice and Procedure (18 CFR 385.214). All protests filed with the Commission will be considered by it in determining the appropriate action to be taken but will not serve to make the protestants parties to the proceeding. Any person wishing to become a party to a proceeding or to participate as a party in any hearing therein must file a motion to intervene in accordance with the Commission's Rules.

Under the procedure herein provided for, unless otherwise advised, it will be unnecessary for applicants to appear or to be represented at the hearing.

**Kenneth F. Plumb,**

*Secretary.*

[FR Doc. 85-20938 Filed 8-30-85; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. CI85-632-000]

## Tenngasco Corp. and Tenngasco Exchange Corp.; Application for Blanket Certificate of Public Convenience and Necessity and for an Order Permitting and Approving Abandonment and Pre-Granted Abandonment

August 27, 1985.

Take Notice that on August 20, 1985, Tenngasco Corporation (Tenngasco) and Tenngasco Exchange Corporation (TGX), pursuant to sections 4 and 7 of the Natural Gas Act, 15 U.S.C. 717-717z (1982) (NGA), and Part 157 of the regulations of the Federal Energy Regulatory Commission (Commission), 18 CFR Part 157 (1984), hereby applied for a blanket certificate of public convenience and necessity (1) authorizing sales for resale of natural gas in interstate commerce by Tenngasco, TGX and the producers from which Tenngasco and TGX purchase natural gas, (2) authorizing sales for resale of natural gas in interstate commerce by producers through Tenngasco and TGX acting as their agents, (3) authorizing blanket partial abandonment and pregranted abandonment of certain sales as described herein, (4) authorizing transportation, where and if necessary, under Section 7(c) of the NGA for interstate pipelines, (5) authorizing pregranted abandonment of such transportation by interstate pipelines, and (6) authorizing transportation by intrastate and Hinshaw pipelines as set forth herein, all to be effective on or before November 1, 1985, as more fully described in the Application which is on file with the Commission and open for public inspection.

Applicants state that the certificate and abandonment authority sought herein, if granted, will enable Tenngasco and TGX to purchase from various producers, and resell, natural gas that remains subject to the Commission's NGA authority for which the maximum lawful price is higher than that established by Section 109 of the Natural Gas Policy Act (NGPA), to act as agent in sales by producers for resale of natural gas that remains subject to the Commission's NGA authority for which the maximum lawful price is higher than that established by Section 109 of the NGPA, and to have such gas, as well as gas which is no longer within the Commission's NGA authority, transported in interstate commerce to all

customers who have the ability to buy gas on the open market.

Tenngasco and TGX are requesting the authority described herein only to the extent that such authority is not provided for in any final rule issued by the Commission in its Notice of Proposed Rulemaking, Regulation of Natural Gas Pipelines After Partial Wellhead Decontrol, Docket No. RM85-1-000 (May 30, 1985) (NOPR), in the event a final rule in the NOPR is not issued by November 1, 1985, and/or in the event any such rule is stayed or not in effect after its issuance.

Tenngasco and TGX, on behalf of themselves, producers, and pipelines, are requesting authority, to be effective no later than November 1, 1985, (1) to make sales for resale in interstate commerce of NGA gas for which the maximum lawful price is higher than the Section 109 price; (2) to temporarily abandon sales for resale of NGA gas for which the maximum lawful price is higher than the Section 109 price and previously certificated by the Commission, to the extent that such gas is released by interstate, intrastate and Hinshaw pipelines, and local distribution companies, to producers for resale either by Tenngasco and TGX or by such producers through Tenngasco and TGX acting as their agents, (3) to abandon (pre-granted abandonment) any sale for resale in interstate commerce authorized pursuant to the blanket certificate issued herein, (4) to have any such gas, as well as natural gas which is no longer subject to the Commission's NGA authority, transported in interstate commerce, on a self-implementing basis, by any transporter to any purchaser, and (5) to abandon (pre-granted abandonment) such transportation.

Such authority, if granted, will enable Tenngasco and TGX to purchase NGA gas for which the maximum lawful price is higher than the Section 109 price (hereinafter referred to as NGA gas) from producers willing to sell to Tenngasco and TGX, for resale on the spot market.

Such authority will also enable Tenngasco and TGX to act as agent for various producers in sales of NGA gas on the spot market. Tenngasco currently acts as agent on behalf of Tenngasco Oil Company (Tenneco Oil) in marketing the majority of Tenneco Oil's gas on the spot market, and will continue to do so. The grant of this authority will allow Tenngasco to continue to market Tenneco Oil's NGA gas. Further, pipelines will be authorized to transport both NGA gas and gas which is no longer subject to the Commission's NGA authority, sold by Tenngasco, TGX and producers on the spot market.

The authority sought by Tenngasco and TGX on behalf of themselves, producers and pipelines, is similar to that recently granted to other marketers of natural gas, it is asserted. The Commission's finding in those cases that such authority will, in particular, aid small independent producers that usually do not participate in the spot market, is equally applicable here. Tenngasco and TGX can ease the administrative burden of such activities on small producers, effect the release of surplus gas where necessary, find purchasers for that gas, and arrange for transportation, on behalf of these producers. Tenngasco and TGX can provide the necessary marketing functions that many producers are not staffed to handle.

Tenngasco and TGX are willing to subject themselves to the Commission's NGA jurisdiction to the extent, and only to the extent, of their participation in these jurisdictional transactions, in the same manner and on the same basis that the Commission's jurisdiction attached to those marketers referred to above. Tenngasco and TGX request that the Commission clarify and declare that Tenngasco and TGX will be subject to the Commission's NGA jurisdiction only to the extent necessary to effectuate the requested authority and only with respect to their participation in the transactions authorized.

Any person desiring to be heard or to make any protest with reference to said application should on or before September 10, 1985, file with the Federal Energy Regulatory Commission, Washington, D.C., 20426, a motion to intervene or protest in accordance with the requirements of the Commission's Rules of Practice and Procedure (18 CFR 385.214). All protests filed with the Commission will be considered by it in determining the appropriate action to be taken but will not serve to make the protestants parties to the proceedings. Any person wishing to be become a party to a proceeding or to participate as a party in any hearing therein must file a motion to intervene in accordance with the Commission's Rules.

Under the procedures herein provided for, unless otherwise advised, it will be unnecessary for Applicants to appear or be represented at the hearing.

**Kenneth F. Plumb,**

*Secretary.*

[FR Doc. 85-20939 Filed 8-30-85; 8:45 am]

BILLING CODE 6717-01-M

## ENVIRONMENTAL PROTECTION AGENCY

**[OPPE-FRL-2889-7]**

### Agency Information Collection Activities Under OMB Review

**AGENCY:** Environmental Protection Agency (EPA).

**ACTION:** Notice.

**SUMMARY:** Section 3507(a)(2)(B) of the Paperwork Reduction Act of 1980 (44 U.S.C 3501 *et seq.*) requires the Agency to publish in the **Federal Register** a notice of proposed information collection requests (ICRs) that have been forwarded to the Office of Management and Budget (OMB) for review. The ICR describes the nature of the solicitation and the expected impact, and where appropriate includes the actual data collection instrument. The following ICR is available for review and comment.

**FOR FURTHER INFORMATION CONTACT:** Nanette Liepman, 202-382-2740 or FTS 382-2740.

**SUPPLEMENTARY INFORMATION:** .

#### Hazardous Waste Programs

Title: Information Requirements for Facilities Petitioning for Hazardous Waste Delisting (ICR #1189). (This is an existing collection.)

Abstract: EPA requires facilities wishing to have a waste removed from the Agency's list of hazardous wastes to file a petition for delisting. Information is necessary to establish that the waste does not exhibit the characteristics for which it was listed and so may be exempted from regulation as hazardous. The Agency reviews this information to determine whether to grant or deny the petition.

Respondents: Owners and operators of hazardous waste management facilities.

#### Agency PRA Clearance Requests Completed by OMB

EPA #0226, Application for Permit to Discharge Wastewater and Associated Regulations, was approved July 18, 1985 (OMB #2040-0086; expires July 31, 1988).

EPA#0807, RCRA Closure and Post Closure, was approved August 7, 1985 (OMB #2050-0008; expires August 31, 1988).

EPA #1238, Part B Application, Reporting and Recordkeeping requirements for Hazardous Waste Tanks, was approved August 19, 1985 (OMB #2050-0050; expires August 31, 1988).

EPA #1246, Asbestos Abatement Worker Protection Rule, was approved June 27, 1985 (OMB #2070–0072; expires June 30, 1988).
EPA #1249, Recordkeeping Requirements for Certified Applicators Using 1080 Collars for Livestock Protection, was approved August 7, 1985 (OMB #2050–0008; expires August 31, 1988).

Comments on all parts of this notice may be sent to:

Nanette Liepman (PM–223) U.S. Environmental Protection Agency Office of Standards and Regulations Regulation and Information Management Division 401 M Street, SW Washington, D.C. 20460

and

Nancy Baldwin
Office of Management and Budget
Office of Information and Regulatory Affairs
New Executive Office Building (Room 3228)
726 Jackson Place, NW.
Washington, D.C. 20503

Dated: August 26, 1985.

**Daniel J. Fiorino,**

*Acting Director, Regulation and Information.*

[FR Doc. 85–20784 Filed 8–30–85; 8:45 am]

BILLING CODE 6560–50–M

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[OW–FRL–2891–4]

## Management Advisory Group to the EPA Construction Grant Program; Open Meeting, September 18–19, 1985

Under Pub. L. 92–463, notice is hereby given that a one and a half day meeting of the Management Advisory Group to the EPA Construction Grant Program (MAG), will be held on September 18–19, 1985, in Washington, D.C. The meeting will begin at 9:00 a.m. on both days.

The principal agenda item will be work on a draft MAG report on compliance and operation and maintenance of publicly owned wastewater treatment works. The agenda will also include briefings and discussions on other topics of current or future interest to MAG. Any member of the public wishing to make comments is invited to submit then in writing to the Executive Secretary at the meeting.

The meeting will be open to the public. The exact location of the meeting in Washington, D.C. has yet to be determined. Any member of the public wishing to know the location of the meeting or receive additional information should contact Georgette Brown at (202) 382–5859.

Dated: August 21, 1985.

**Henry L. Longest II,**

*Acting Assistant Administrator, Office of Water (WH–556).*

[FR Doc. 85–20931 Filed 8–30–85; 8:45 am]

BILLING CODE 6560–50–M

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[OPTS–00064A; FRL–2890–1]

## Interagency Toxic Substances Data Committee; Cancellation of Meeting

**AGENCY:** Environmental Protection Agency (EPA).

**ACTION:** Notice.

**SUMMARY:** The September 10, 1985 meeting of the Interagency Toxic Substances Data Committee has been cancelled.

**FOR FURTHER INFORMATION CONTACT:** Gerhard Brown (TS–793), Executive Secretary, Interagency Toxic Substances Data Committee, Office of Pesticides and Toxic Substances, Environmental Protection Agency, Rm. E–333, 401 M St., SW., Washington, D.C. 20460, (202–382–3634).

**SUPPLEMENTARY INFORMATION:** The regular meetings of the Interagency Toxic Substances Data Committee usually take place on the first Tuesday of alternate months at 9:30 a.m. and are open to the public. The meetings are held in: First Floor Conference Room, Council on Environmental Quality, 722 Jackson Pl., NW., Washington, D.C. 20006.

The September meeting has been cancelled. The next meeting of the Interagency Toxic Substances Data Committee will take place on November 5, 1985.

Dated: August 26, 1985.

**Gerhard Brown,**

*Executive Secretary, Interagency Toxic Substances Data Committee.*

[FR Doc. 85–20930 Filed 8–30–85; 8:45 am]

BILLING CODE 6560–50–M

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[OPTS–140066; FRL–2890–7]

## Access to Confidential Business Information by Life Systems, Inc.

**AGENCY:** Environmental Protection Agency (EPA).

**ACTION:** Notice.

**SUMMARY:** EPA will provide its contractor, Life System, Inc., (LSI) of Cleveland, Ohio, with access to information submitted to EPA or collected by the Agency under the Toxic Substances Control Act (TSCA). Some of the information may be claimed or determined to be confidential business information (CBI).

**DATE:** Access to CBI under this contract will not take place prior to September 13, 1985.

**FOR FURTHER INFORMATION CONTACT:** Edward A. Klein, Director, TSCA Assistance Office (TS–799), Office of Toxic Substances, Environmental Protection Agency, Rm. E–543, 401 M St., SW., Washington, D.C. 20460, Toll-Free: (800–424–9065). In Washington, D.C.: (554–1404). Outside the USA: (Operator–202–554–1404).

**SUPPLEMENTARY INFORMATION:** Under TSCA, EPA must determine whether the manufacture, processing, distribution in commerce, use, or disposal of certain chemical substances or mixtures may present an unreasonable risk of injury to human health or to the environment. EPA must evaluate new chemicals, i.e., those not listed on the TSCA Inventory of Chemical Substances, under section 5 of TSCA. Existing chemicals, i.e., those listed on the TSCA Inventory, are evaluated by EPA under sections 4, 6, 7, and 8 of TSCA.

Under EPA contract number 68–02–4228, LSI, 24755 Highpoint Road, Cleveland, Ohio, will assist the Office of Toxic Substances in assessing new and existing chemicals for health and environmental effects. LSI will, among other things, perform peer reviews of technical documents prepared under sections 4, 5, 6, and 8 of TSCA, analyze scientific issues related to regulatory policy options, and prepare or revise proposed test standards and guidelines.

In accordance with 40 CFR 2.306(j), EPA has determined that LSI will require access at its facilities in Cleveland, Ohio and at 1725 Jefferson Davis Highway, Suite 803, Arlington, Virignia, to confidential information submitted to the Agency under all sections of TSCA and to automated systems at EPA Headquarters containing data from such submissions to perform work under the above-mentioned contract successfully. EPA is issuing this notice to inform all submitters of information under these sections of TSCA that it will authorize LSI for access to these categories of information. LSI was previously authorized for access to TSCA CBI under contract number 68–01–6554, announced in th **Federal Register** of June 22, 1982 (47 FR 26909).

LSI has been authorized for access to TSCA CBI through September 30, 1986, under the EPA "Contractor Requirements for the Control and Security of TSCA Confidential Business Information" manual. LSI's security plan and physical security facilities have been approved by TSCA Security Staff.

Contractor personnel will be required to sign non-disclosure agreements and will be briefed on appropriate security procedures before they are authorized for access to TSCA CBI. All CBI materials will be returned to EPA upon completion of LSI's review.

Dated: August 26, 1985.

**Don R. Clay,**

*Director, Office of Toxic Substances.*

[FR Doc. 85-20926 Filed 8-30-85; 8:45 am]

BILLING CODE 6560-50-M

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[OW-10-FRL-2890-9]

## Water Pollution; National Pollutant Discharge Elimination System (NPDES) Permits; State Determination of Consistency With the Alaska Coastal Zone Management Program

**AGENCY:** Environmental Protection Agency (EPA).

**ACTION:** Notice.

Revised Public Notice Expiration dates for:

Public Notice No. AKG285000 (Cook Inlet/Gulf of Alaska) Original Public Notice Expiration Date: August 19, 1985 Revised Public Notice Expiration Date: September 18, 1985 (50 FR 28974, July 17, 1985)

Public Notice No. AKG286000 (Bering Sea Area II) Original Public Notice Expiration Date: August 23, 1985; Revised Public Notice Expiration Date: September 23, 1985 (50 FR 29928, July 22, 1985)

*Public Comments:* The public comment periods for the above permits have been extended 30 days. Persons wishing to provide comments on the draft permits listed above must ensure that EPA, Region 10, receives the comments by 4 p.m. on the dates shown above.

Dates for tentatively-scheduled public hearings on these draft permits will not be affected by the comment period extension.

**FOR FURTHER INFORMATION CONTACT:**

Kerrie Schurr (regarding the Cook Inlet/Gulf of Alaska draft permit), Telephone No. (206) 442-1774;
or
Duane Karna (regarding the Bering Sea Area II draft permit), Telephone No. (206) 442-1413, Ocean Programs Section, Environmental Protection Agency, Region 10, 1200 Sixth Avenue, Seattle, Washington 98101-3188.

Dated: August 21, 1985.

**Robert S. Burd,**

*Director, Water Division.*

[FR Doc. 85-20942 Filed 8-30-85; 8:45 am]

BILLING CODE 6560-50-M

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## FEDERAL COMMUNICATIONS COMMISSION

### Approval of Agency Information Collection Requirement by OMB

August 26, 1985.

The following information collection requirement has been approved by the Office of Management and Budget. For further information contact Doris Peacock, FCC, (202) 632-7513.

OMB No: 3060-0104
Title: Temporary Permit to Operate a Part 90 Radio Station
Form No.: FCC 572

The approval on FCC 572 has been extended through 8/3/88. The October 1982 edition with an OMB expiration date of 9/30/85 will remain in use until updated forms are available.

**William J. Tricarico,**

*Secretary, Federal Communications Commission.*

[FR Doc. 85-20891 Filed 8-30-85; 8:45 am]

BILLING CODE 6712-01-M

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### St. Clement's Episcopal Parish School et al.; Hearing Designation Order

In re Applications of: St. Clement's Episcopal Parish School (Inc.), MM Docket No 85-264; File No. BPET-850114KF; El Paso County Community College District, File No. BPET-850228KG, For Construction Permit El Paso, Texas.

Adopted: August 19, 1985.
Released: August 26, 1985.

By the Chief, Video Services Division.

1. The Commission, by the Chief, Video Services Division, acting pursuant to delegated authority, has before it the above-captioned mutually exclusive applications of St. Clement's Episcopal Parish School (Inc.) (St. Clement's), and El Paso County Community College District (Community College) for authority to construct a new non-commercial educational television station on Channel 38, El Paso, Texas.

2. Applicants for new broadcast stations are required to give local notice of the filing of their applications, in accordance with § 73.3580 of the Commission's Rules. They must then file proof of publication of such notice or certify that they have or will comply with the public notice requirement. We have no evidence, however, that St. Clement's has done either. If it has not already done so, St. Clement's will be required to file a statement that it has or will comply with the public notice requirement with the adminstrative Law Judge within 20 days of the release of this Order.

3. Except as indicated by the issues specified below, the applicants are qualifed to construct and operate as proposed. Since these applications are mutually exclusive, the Commission is unable to make the statutory finding that their grant will serve the public interest, convenience, and necessity. Therefore, the applications must be designated for hearing in a consolidated proceeding on the issues specified below.

4. Accordingly, it is ordered, that pursuant to section 309(e) of the Communications Act of 1934, as amended, the applications are designated for hearing in a consolidated proceeding, to be held before an Administrative Law Judge at a time and place to be specified in a subsequent Order, upon the following issues:

1. To determine the extent to which each applicant's proposed operation will be integrated into the overall cultural and educational objectives of the respective applicants;

2. To determine the manner in which each applicant's proposed operation meets the needs of the community to be served;

3. To determine whether the factors in the record demonstrate that one applicant will provide a superior non-commercial educational broadcast service.

4. To determine, in light of the evidence adduced pursuant to the foregoing issues, which of the applications should be granted.

5. It is further ordered, That St. Clement's Episcopal Parish School (Inc.) shall file a certification with the presiding Administrative Law Judge, within 20 days after this Order is released, that it has or will comply with § 73.3580 of the Commission's Rules.

6. It is further ordered, that, to avail themselves of the opportunity to be heard, the applicants herein shall, pursuant to § 1.221(c) of the Commission's Rules, in person or by attorney, within 20 days of the mailing of this Order, file with the Commission, in triplicate, a written appearance stating an intention to appear on the date fixed for the hearing and to present evidence on the issues specified in this Order.

7. It is further ordered, that the applicants herein shall, pursuant to section 311(a)(2) of the Communications Act of 1934, as amended, and § 73.3594 of the Commission's Rules, give notice of the hearing within the time and in the manner prescribed in such Rule, and shall advise the Commission of the publication of such notice as required by § 73.3594(g) of the Rules.

Federal Communications Commission.
Roy J. Stewart,
*Chief, Video Services Division, Mass Media Bureau.*
[FR Doc. 85-20892 Filed 8-30-85; 8:45 am]
BILLING CODE 6712-01-M

## FEDERAL HOME LOAN BANK BOARD

[No. 85-759]

### Prices for Federal Home Loan Bank Services

August 26, 1985.

**AGENCY:** Federal Home Loan Bank Board.

**ACTION:** Notice of prices for Federal Home Loan Bank Services.

**SUMMARY:** The Office of District Banks and the Office of Policy And Economic Research of the Federal Home Loan Bank Board are publishing, pursuant to delegated authority, the prices charged by the Federal Home Loan Banks for: (1) Processing and settlement of items and (2) demand deposit services offered to member institutions.

**EFFECTIVE DATE:** September 3, 1985.

**FOR FURTHER INFORMATION CONTACT:** Ashley C. Speir, Jr., (202-377-6656) Office of District Banks, Federal Home Loan Bank Board, 1700 G Street, NW., Washington, D.C. 20552.

**SUPPLEMENTARY INFORMATION:** Section 11(e) of the Federal Home Loan Bank Act (12 U.S.C. 1431(e)) authorizes the Federal Home Loan Banks: (1) To accept demand deposits from member institutions, (2) to be drawees of payment instruments, (3) to engage in collection and settlement of payment instruments drawn on or issued by members and eligible institutions, and (4) to engage in such incidental activities as are necessary to the exercise of such authority.

Section 11(e)(2)(B) of the Bank Act (12 U.S.C. 1431(e)(2)(B)) requires the Federal Home Loan Banks to charge fees for services authorized in that section, which fees are "to be determined and regulated by the Board consistent with the principles set forth in section 11A(c) of the Federal Reserve Act." Board regulations at 12 CFR 534.6 require that the Director of the Office of District Banks and the Director of the Office of Policy and Economic Research (or their designees) review, approve, and publish these fees at least annually. The regulations specify that the fees must be reviewed in accordance with the following pricing principles:

(1) In determining the fees for services provided under this part, a Federal Home Loan Bank must take into account all direct and indirect costs of providing the services.

(2) Prices must reflect the imputed rate of return that would have been earned and the taxes that would have been paid if the Bank were a private corporation, by using a cost of capital adjustment factor applied to those assets used in providing services authorized under this Part.

(3) All costs must be fully recovered within a period not exceeding five years. The prices charged for collection, processing, and settlement services must yield at least a competitive rate of return within a period not exceeding five years after offering such services.[1]

In accordance with these principles, the Director of the Office of District Banks and the Director of the Office of Policy and Economic Research have reviewed and approved the current prices for Federal Home Loan Bank services, which are published herewith. The services and their prices are divided into two categories: (1) Services involved in the processing and settlement of items drawn on or issued by member institutions (Schedule A); and (2) service relating to demand deposit accounts maintained by member institutions with the Banks (Schedule B).

The services described in the attached schedules are not identical for any two Banks, as each Bank's program is tailored to meet the needs of the member institutions in the Bank's district. Furthermore, the volume of services rendered varies significantly among the districts, with the result that the costs of providing the services also vary from district to district. In light of these considerations, the Board continues its practice of approving separate district fee structures rather than adopting a uniform pricing scheme. This policy is consistent with the congressional intent that pricing encourage competition.

It is not required that each processing step or transaction performed by a Bank be specifically priced. This policy permits the Banks to establish fee schedules that are in line with the marketing practices of providers of correspondent services in each district. However, total revenue from services must be sufficient to cover costs. In the case of item processing and settlement services, fees must be sufficient to recover all start-up costs within five years. Demand deposit service expenses must be recovered annually, because the Banks have provided these services for many years, and thus have attained mature service volumes.

The price analysis incorporates an imputed cost of captial adjustment factor of fifteen percent. This adjustment factor is required by 12 CFR 534.6(b)(2) in order to yield a fee structure competitive with prices charged by private-sector services. The current fifteen-percent figure was derived in accordance with a formula which is described in detail at 45 FR 64161 (Sept. 29, 1980).

The directors of the Office of District Banks and the Office of Policy and Economic Research of the Federal Home Loan Bank Board hereby give notice of the following fee schedules for Federal Home Loan Bank services:

**Schedule A: Item Processing and Settlement Services**

DISTRICT 1.—FEDERAL HOME LOAN BANK OF BOSTON

(Services not provided)

DISTRICT 2.—FEDERAL HOME LOAN BANK OF NEW YORK

| Service | Fee |
|---|---|
| Settlement (per month) | $75.00 |
| Standard intercept (per item) | .02 |
| Standard intercept-delayed check (per item) | .02 |
| Check safekeeping: | |
| First 100,000 items/month (per item) | .015 |
| 100,001 plus items/month (per item) | .010 |
| Bulk filing: | |
| First 100,000 items/month (per item) | .020 |
| 100,001 plus items/month (per item) | .015 |
| Statement rendering: | |
| Bulk filing with items (per statement) | .30 |
| Check safekeeping without items (per statement) | .05 |
| Stop payment, suspect item, and certified item file (per entry) | 1.00 |
| Automatic item returns (per item) | 2.50 |
| Photocopies (per copy) | 2.00 |
| Original item retrieval (per item) | 4.00 |
| Datafax high dollar items (per item) | 1.00 |
| Counter item filing (per item) | .02 |
| Counter item sorting (per item) | .005 |
| Notices or advertising inserts (per insert) | .005 |
| Microfilm monthly history (per 100,000 items) | 5.00 |
| Now transaction history-additional copies (per fiche card) | 1.00 |
| Held paid item filming (per item) | .02 |

DISTRICT 3.—FEDERAL HOME LOAN BANK OF PITTSBURGH

(For members located in the Third and Fourth Reserve Districts.)

| Services | Fee |
|---|---|
| Processing: | |
| First 50,000 items/month (per item) | $0.0380 |
| 50,001-100,000 items/month (per item) | .0362 |
| 100,001-150,000 items/month (per item) | .0344 |
| 150,001-200,000 items/month (per item) | .0326 |
| Over 200,000 items/month (per item) | .0308 |

[1] By Resolution No. 82-211, the Board proposed to substitute a ten-year rule for this five-year requirement. 47 FR 57293 (December 23, 1982). No final action has been taken with respect to the proposal; however, the Board still has it under consideration.

[For members located in the Fifth Federal Reserve District]

| Items/Month | Daily return unsorted | Daily return sorted | Truncation | Bulk filing without stuffing | Bulk with stuffing |
|---|---|---|---|---|---|
| First 10,000 | $.0375 | $.0500 | $.0500 | $.0575 | $.0875 |
| Next 20,000 | .0325 | .0450 | .0450 | .0525 | .0825 |
| Next 20,000 | .0300 | .0425 | .0425 | .0500 | .0800 |
| 50,000 and Over | .0225 | .0350 | .0350 | .0425 | .0725 |

| Special Services | Fee |
|---|---|
| Check retrieval or inspection of original item | $1.50 |
| Photocopy | 2.50 |
| Advertising insertion (per item) | .01 |
| Posted—"on-us" (per item) | .03 |
| Statement stuffing for truncated statements (per statement) | .01 |
| Statement stuffing of deposit tickets and dishonored notices (per item) | .09 |
| Return items processed by bank (per item) | 2.50 |
| Additional sorting upon request: | |
| Fine sorting (per item) | .005 |
| Cycle sorting (per item) | .005 |

## District 4.—Federal Home Loan Bank of Atlanta

| Services | Fee |
|---|---|
| Settlement only (per month) | $50.00 |
| Daily delivery (same day and next day): | |
| 1st 50,000 (per item) | .03 |
| Over 50,000 (per item) | .025 |
| Bulk filing: | |
| 1st 50,000 (per item) | .035 |
| Next 50,000 (per item) | .030 |
| Over 100,000 (per item) | .025 |
| Statement matching: | |
| 1st 50,000 (per item) | .060 |
| Next 50,000 (per item) | .055 |
| Over 100,000 (per item) | .050 |
| Truncation: | |
| 1st 50,000 (per item) | .025 |
| Next 50,000 (per item) | .020 |
| Over 100,000 (per item) | .015 |
| Caution/alert (stop payment) | 2.00 |
| Facsimile: | |
| Large dollar (per item) | 2.00 |
| On request (per item) | 1.50 |
| Bookeeping and acc't no. rejects (per item) | 2.00 |
| Over-the-counter items (per item) | .015 |
| Photocopies (per item) | 2.00 |
| Finesort (check number)—Special Accounts | .02 |

Note.—Minimum monthly billing for service options (other than Settlement Only) is $75.00.)

## District 5.—Federal Home Loan Bank of Cincinnati

| Service | Fee |
|---|---|
| Settlement Only (per month) | $50.00 |
| Check retrieval or inspection of original item (per item) | 1.50 |
| Photocopy (per copy) | 1.00 |
| Advertising insertion (per item) | .01 |
| Posted "on-us" (per item) | .03 |
| Statement stuffing service for truncated statements (per statement) | .01 |
| Statement stuffing of deposit tickets and dishonored notices (per item) | .09 |
| Return items processed by bank (per item) | 2.50 |
| Additional sorting upon request: | |
| Fine sorting (per item) | .005 |
| Cycle sorting (per item) | .005 |

### Service

| Items/month | Daily return unsorted | Daily return sorted | Truncation | Bulk filing w/ stuffing | Bulk filing w/out stuffing |
|---|---|---|---|---|---|
| 0–25,000 | $.0350 | $.0375 | $.0375 | $.0750 | $.0400 |
| 25,001–50,000 | .0275 | .0300 | .0300 | .0675 | .0325 |
| 50,001–75,000 | .0200 | .0225 | .0225 | .0900 | .0250 |
| 75,001–100,000 | .0150 | .0175 | .0175 | .0550 | .0200 |
| 100,001–125,000 | .0100 | .0125 | .0125 | .0500 | .0150 |
| 125,001–150,000 | .0075 | .0100 | .0100 | .0475 | .0125 |
| 150,001 and over | .0050 | .0075 | .0075 | .0450 | .0100 |

## District 7.—Federal Home Loan Bank of Chicago—Service

| Items per month | Daily returns | 24-hour delay | Bulk file | Truncation |
|---|---|---|---|---|
| 0 to 50,000 | $.025 | $.024 | $.023 | $.020 |
| 50,001 to 100,000 | .024 | .023 | .022 | .019 |
| 100,001 to 150,000 | .023 | .022 | .021 | .018 |
| 150,000 and over | .022 | .021 | .020 | .017 |

| Service | Fee |
|---|---|
| Counter items (per item) | $0.025 |
| Return items (per item) | 4.00 |
| Photocopies (per item) | 3.00 |
| Facsimile of items (per page) | 2.00 |
| Cash letter facsimile (per page) | 2.00 |
| Special sorts (per item) | .015 |
| Monthly recap (per item) | .0025 |
| Data transmission (per item) | .0030 |
| NOW settlement only (per month) | 100.00 |

## District 6.—Federal Home Loan Bank of Indianapolis

| Service | Fee |
|---|---|
| Settlement only (per month) | $40.00 |
| Minimum processing fee (per month) | 40.00 |
| Over-the-counter items (per item) | .035 |
| Microfilm | .035 |
| Exception safekeeping statements | .25 |
| Photocopies and facsimiles | 2.00 |
| Facsimile items for signature verification on day of presentment | (1) |
| Return items | 2.75 |

[1] Fees for daily/cycle return, monthly return or monthly return with microfilm are in addition to the basic (truncated) fee.

### Service

| Item per/month | Safekeeping | Turnaround (daily or cycled) | Complete |
|---|---|---|---|
| 0 to 5,000 | $0.045 | $0.053 | $0.077 |
| 5,001 to 10,000 | .037 | .048 | .075 |
| 10,001 to 15,000 | .036 | .044 | .073 |
| 15,001 to 25,000 | .031 | .037 | .072 |
| 25,001 to 50,000 | .030 | .033 | .070 |
| 50,001 to 75,000 | .026 | .030 | .068 |
| 75,001 to 100,000 | .023 | .027 | .065 |
| 100,001 to 125,000 | .021 | .024 | .064 |
| 125,001 to 150,000 | .019 | .022 | .063 |
| 150,001 to 175,000 | .017 | .020 | .062 |
| 175,001 and up | .014 | .018 | .059 |

## District 8.—Federal Home Loan Bank of Des Moines

[Services]

| Item processing volume level | Basic fee (truncated) | Daily cycle [1] | Monthly [1] | Monthly/film [1] |
|---|---|---|---|---|
| 1 to 10,000 | $.021 | $.016 | $.021 | $.026 |
| 10,001 to 25,000 | .019 | .014 | .019 | .024 |
| 25,001 to 50,000 | .017 | .012 | .017 | .022 |
| 50,001 to 75,000 | .015 | .010 | .015 | .020 |
| 75,001 to 175,000 | .0125 | .0075 | .0125 | .0180 |
| 175,001 to 400,000 | .012 | .006 | .010 | .015 |
| Bulk pricing 400,001 and over | .01 | .006 | .010 | .015 |

[1] Fees for daily/cycle return, monthly return or monthly return with microfilm are in addition to the basic (truncated) fee.

### Other Services

| Service | Fee |
|---|---|
| Tape and tranamission preparation | $0.0002 |
| Key punch (rejects) | .04 |
| Photo copies | 2.75 |
| Signatures verified | [1].70 |
| Counter items with microfilm | .04 |
| Fascimile transmission | 1.00 |
| Microfiche-monthly reports | 1.50 |
| Microficha-copies | .18 |
| Return items | 2.50 |
| Stop payments | 2.00 |
| Original item return | 2.75 |
| Certified checks | .50 |
| Counter items without MICR encoding | .10 |
| Fascimile transmission of daily cash letter | 1.00 |
| NOW transaction inquiry | 1.00 |
| Telephone advice on missing account No | .50 |
| Microfilm copies for audit | 10.00 |
| Telephone check inquiry | 1.00 |

[1] Dollar amount variable by association.

Note.—Minimum processing fee of $40.00 per month will apply for total NOW services.

## District 8.—Federal Home Loan Bank of Des Moines (Continued)

| | Fee |
|---|---|
| Statement per month—Non-truncated: | |
| First 2,000 | $0.24 |
| Next 4,000 | .21 |
| Next 4,000 | .19 |
| Next 4,000 | .17 |
| Next 4,000 | .15 |
| Statement per month—truncated | .05 |
| Statement inserts | .005 |
| Surcharge for one cycle per month | (1) |
| Fine sort counter items for statement insertion | .005 |
| Sort Counter Items without MICR | .02 |

[1] Ten percent.

Note.—Associations that have changed data processors and have more than one MICR account number corresponding to one statement account number are subject to additional fees.

## District 9.—Federal Home Loan Bank of Dallas—Service

| Basic service—items/month | Cycle-Daily [1] | Truncate |
|---|---|---|
| Tier 1: 0 to 50,000 | $0.036 | $0.030 |
| Tier 2: 50,001 to 100,000 | .030 | .025 |
| Tier 3: 100,001 to 150,000 | .025 | .020 |
| Tier 4: 150,001 to 200,000 | .020 | .015 |
| Tier 5: 200,001 to Over | .014 | .010 |

| Special services (per item) | Fee |
|---|---|
| Counter item integration | $0.036 |
| Receive, microfilm, and fine sort with checks presently on hand at the FHLBank and store for truncation or delivery to association. | |

### DISTRICT 9.—FEDERAL HOME LOAN BANK OF DALLAS—SERVICE—Continued

| Special services (per item) | Fee |
|---|---|
| Return items | 3.00 |
| Fee for sorting and returning any items (NSF's stop payments, etc.) An additional $.50 will be added to reflect Federal Reserve Bank charges for checks processed through FRB Dallas, Houston, San Antonio and El Paso. | |
| Stop payment file | 2.00 |
| Fee for receiving and placing on file holds, stop pays, closed accounts, etc. | |
| Photocopies or original check retrieval | 1.50 |
| Postage | (1) |

[1] An additional $.006 for month end.
[2] Acutal cost.

### DISTRICT 10.—FEDERAL HOME LOAN BANK OF TOPEKA

| Level | Truncated | Fee per check cycle return |
|---|---|---|
| Processing Fees | | |
| A First 10,000 | $0.02 | $0.035 |
| B Next 15,000 | .018 | .034 |
| C Next 25,000 | .016 | .032 |
| D Next 200,000 | .014 | .03 |
| E Next 250,000 | .011 | .027 |
| F Each Over 500,000 | .01 | .026 |

### DISTRICT 10.—FEDERAL HOME LOAN BANK OF TOPEKA—Continued

| Level | Truncated | Fee per check cycle return |
|---|---|---|
| Other Services | | Fee |
| Return items—1st 50 (monthly) (per item) | | $2.50 |
| Over 50 (per item) | | 1.00 |
| Settlement—(w/FHLB processing) | | (1) |
| Settlement only (per month) | | 50.00 |
| Item Retrieval (Photocopy) (per item) | | 2.00 |
| Over-the-counter items (microfilmed and filed per item) | | .03 |
| Facsimile transmissions (listing of paid item—per transmission) | | 1.50 |

[1] No charge.

### DISTRICT 11.—FEDERAL HOME LOAN BANK OF SAN FRANCISCO

| Service | Volume price based on total items per month | | | | |
|---|---|---|---|---|---|
| | Less than 50,000 | 50,000 to 250,000 | 250,001 to 500,000 | 500,000 to 1,000,000 | 1,000,000 and more |
| Basic capture service (min. charge $500/mo.): | | | | | |
| Capture/fine/sort/microfilm | $0.0400 | $0.0350 | $0.0300 | $0.0220 | $0.0190 |
| Return item processing | 2.00 | 1.75 | 1.50 | 1.25 | 1.00 |
| Comprehensive NOW service (min. charge $750/mo.): | | | | | |
| Capture/file/microfilm/fine sort | .400 | .0350 | .0300 | .0220 | .0190 |
| Statement preparation (truncated) | .15 | .14 | .13 | .12 | .12 |
| Statement preparation (standard) | .35 | .30 | .28 | .26 | .24 |
| Return item processing | 2.00 | 1.75 | 1.50 | 1.25 | 1.00 |
| Over-the-counter items | .045 | .045 | .045 | .045 | .045 |
| Statement inserts | .03 | .03 | .03 | .03 | .03 |

| | Fee |
|---|---|
| Miscellaneous Services: | |
| Late return item transmission—after 2:00 p.m. (per item) | $.25 |
| Second request on previously reconciled adjustment (per occurrance) | 10.00 |
| Truncated item retrieval (per item) | 3.00 |
| Data Line/Gasco generic envelopes (each) | .025 |
| Reconciliation of member books (per hour) | 25.00 |
| Microfilm: | |
| Second copy of film daily (per month) | 75.00 |
| Special request copy (per copy) | 5.00 |
| Microfiche: | |
| Output report—2 copies each (per month) | 50.00 |
| Additional copies (per copy) | 1.00 |
| Special fine sort (per item) | .03 |
| Photocopies (per copy) | 2.00 |
| Non-standard statement inserts (per insert) | .05 |
| MICR line alterations (per item) | 4.00 |
| Supplementary Service Fees: Thirty day advance notice is required on all branch sales, branch mergers, branch acquisitions or service bureau charges. | |
| Custom Programming: | |
| 1. Breakout of items by routing transit number and/or branch number (incl. listing) | 2,000.000 |
| 2. Breakout and capture of items (Processed items list/microfilm/commingled with other items for service bureau) | 3,000.000 |
| 3. Breakout, capture, and separate tape produced, including above items | 4,500.000 |
| 4. Selective account programming (maximum 50 accounts) in addition to regular programming requirements | 1,500.00 |
| 5. One-half of the original programming fee will be assessed in the event of a cancellation notice given less than 7 days in advance of effective date. | |
| Statement Handling: | |
| Set-up fee/branch outsort of items | 250.00 |
| Standard statement rendition (close-out statement) (each) | .50 |
| Non-standard statement rendition: | |
| First 90 days (each) | .75 |
| After 90 days (each | 1.00 |

### DISTRICT 12.—FEDERAL HOME LOAN BANK OF SEATTLE

| Item/per month | Services | | | |
|---|---|---|---|---|
| | Daily return | Truncation | Bulk file | Statement stuffing |
| A. Seattle processing center: | | | | |
| 0 to 50,000 | $0.0250 | $0.0300 | $0.0350 | $0.0600 |
| 50,001 to 100,000 | .0200 | .0250 | .0300 | .0550 |
| 100,001 to 200,000 | .0175 | .0225 | .0275 | .0525 |
| 200,001 and up | .0150 | .0200 | .0250 | .0500 |
| B. Honolulu processing center: | | | | |
| 0 to 50,000 | .0350 | .0400 | .0450 | .0700 |
| 50,001 to 100,000 | .0300 | .0350 | .0400 | .0650 |
| 100,001 to 200,000 | .0275 | .0325 | .0375 | .0625 |
| 200,001 and up | .0250 | .0300 | .0350 | .0600 |
| C. Additional services and charges. | | | | |

| Service | Seattle center | Honolulu center |
|---|---|---|
| Transportation charges for items outside of the Seattle Federal Reserve clearing district (except for Regional Processing Centers) (per ..... item) | $0.005 | $0.005 |
| Return item handling (per item) | .75 | .50 |
| Facsimile transmissions (per item) | .75 | .50 |
| Large dollar verification (per item) | .75 | .50 |
| Research requests (per item) | .75 | .50 |
| Fine sort only (per item) | .006 | .006 |
| Settlement only (per item) | 125.00 | 125.00 |

## Schedule B: Demand Deposit Services

### District 1.—Federal Home Loan Bank of Boston

| Services | Fee |
|---|---|
| Checks and items Paid (per item) | $0.12 |
| Deposits (per item) | .20 |
| Debit/credit memos: | |
| Federal Reserve settlement (per item)[1] | .30 |
| Internal transfer | ([2]) |
| Others (per item) | .10 |
| Wire transfer: | |
| In (per item) | 2.50 |
| Out (per item) | 5.00 |
| Account maintenance (per month) | 5.00 |
| Special statements (per statement) | 2.00 |
| Stop Payment Orders (per item) | 7.50 |
| Account reconciliations: | |
| Paper issues (per item) | .05 |
| Magnetic Tape Issues (per item) | .035 |

[1] Federal Reserve Settlements include ACH, Series E-Bond Redemption, Cash Letter Settlements (inclearings and Outclearings), Regulation D Reserve Pass-Throughs, Treasury Tax and Loan Settlements.
[2] No Charge.

### District 2.—Federal Home Loan Bank of New York

| Service | Fee |
|---|---|
| Teller checks and money orders:[1] | |
| First 10,000 items/month (per item) | $0.195 |
| 10,001 plus items/month (per item) | .145 |
| Wire transfers: | |
| In (per wire) | ([2]) |
| Out (per wire) | 7.50 |
| Depository transfer checks (per check) | 1.00 |
| Collections: Coupon processing, bond redemption and recurring payments (per transaction) | 4.00 |
| Safekeeping: Purchases, Sales and Maturities (per transaction) | 40.00 |
| Special service fees: | |
| Saturday premium (per item) | .01 |
| Cash letter deposit (per desposit) | .50 |
| Return items (per return) | 1.25 |
| Non cash collection (per item) | 3.50 |
| Security coupon collection (per envelope) | 3.50 |

[1] The indicated fee covers all aspects of check service including the cost of blank instruments, stop payment orders, inquiries and photocopies of paid items stored on microfilm. Blank stock is resupplied automatically, and other forms such as stop payment orders, photo request cards, check control sheets and address labels are supplied on request.
[2] No charge.

### District 3.—Federal Home Loan Bank of Pittsburgh

| Service | Fee |
|---|---|
| Deposit processing service: | |
| Deposit ticket entry (per entry) | $0.25 |
| Deposit transfer voucher (per entry) | .75 |
| Mail deposit entry (per entry) | 1.75 |
| Deposit item processing (per item) | .013 |
| Deposit item encoding (per item) | .03 |
| Deposit item return (per item) | 1.25 |
| Deposit item photocopy (per item) | 2.00 |
| Deposit pickup (per pickup) | 6.75 |
| Check and money order clearing service: | |
| Clearing item processing (per item) | .0667 |
| Clearing item reconciliation copy processing: | |
| By manual input (per item) | .04 |
| By magentic tape input (per item) | .01 |
| Clearing item fine sorting for Return with Bank Statements (per item) | .05 |
| Stop Payment Orders (per entry) | 6.00 |
| Imprinting checks and money orders | ([1]) |
| Standard earnings checks (per item) | .05 |
| Wire transfer of funds: | |
| Outgoing (per transfer) | 5.25 |
| Incoming (per transfer) | 3.25 |
| Lockbox service: | |
| Lockbox item processing (per item) | .11 |
| Deposit item processing (per item) | .03 |
| Deposit ticket entry (per entry) | .25 |
| Transportation (per month) | 20.00 |
| Account maintenance (per acct./month) | 6.75 |
| Account overdraft penalty [2] | |

[1] Actual cost.
[2] Greater of $75 or interest for one day on the amount of the overdraft at the highest advance rate plus 3 percent.

### District 4.—Federal Home Loan Bank of Atlanta

| Service | Fee |
|---|---|
| Checks paid [1] (per item): | |
| Monthly statement w/items fine sorted | $0.12 |
| Monthly statement w/items truncated | .08 |
| Stop payment (per item) | 6.00 |
| Deposit transfer checks (DTC) (per item) | 4.00 |
| Wire transfers: | |
| In (per transfer) | 4.00 |
| Out (per transfer) | 4.00 |
| Account reconciliation service: | |
| Full reconciliation-magnetic tape ($20.00 min./mo.) (per issue) | .03 |
| Full reconciliation-paper issue ($20.00 min./mo.): | |
| Encoded amounts (per issue) | .0425 |
| Unencoded amounts (per issue) | .06 |
| Partial reconciliation ($10.00 min./mo.) (per item) | .03 |
| Deposit processing: | |
| Unencoded checks (per item) | 0.525 |
| Encoded checks (per item) | .0350 |
| Foreign checks (per item) | 2.50 |
| Bond coupons (per envelope) | 3.00 |
| Deposited checks returned (per entry) | 2.50 |
| Automated clearinghouse (ACH) service: | |
| Originating-$15.00 per tape plus per item | .03 |

### District 4.—Federal Home Loan Bank of Atlanta—Continued

| Service | Fee |
|---|---|
| Receiving-$50.00 settlement per month plus per item charge | .03 |
| Settlement only service: | |
| Automated clearinghouse (ACH) (per month) | 50.00 |
| Currency and con (per month) | 50.00 |
| Treasury tax and Loan (TT&L) (per entry) | 2.50 |
| Savings bonds (per entry) | 2.50 |
| Deposit of items at Fed (per month) | 50.00 |
| Non-cash collections (per entry) | 2.50 |
| Currency and coin service (full): $50.00 settlement/month plus per order | 2.50 |
| Account maintenance (per month) | 5.00 |

[1] The checks paid charge includes at no additional charge: Internal transfers, special settlement drops, photocopies, and return of items not paid.

### District 5.—Federal Home Loan Bank of Cincinnati

| Service | Fee | |
|---|---|---|
| | En-coded | Unen-coded |
| Items per month: | | |
| 0 to 25,000 | $.0475 | $.0575 |
| 25,001 to 50,000 | .0450 | .0550 |
| 50,001 to 75,000 | .0425 | .0525 |
| 75,001 to 100,000 | .0400 | .0500 |
| 100,001 to 150,000 | .0375 | .0475 |
| 150,001 to Over | .0350 | .0450 |
| Distribursement: | Per item charge | |
| Reconciled paid items | $0.060 | |
| Unreconciled paid item | .165 | |
| Magnetic tape | .045 | |
| Advices | .010 | |
| Other services: | | |
| Stop payments | $2.00 | |
| Wire transfer-in | 2.00 | |
| Wire transfer-out | 5.00 | |
| Charges | .11 | |
| Credits | .11 | |
| Photocopies | 1.00 | |
| Depository transfer check (DTC) | 2.50 | |
| Dishonored item: | | |
| Returned to association | 1.00 | |
| Automatically re-deposited | ([1]) | |
| Non-cash collection service: | | |
| Non-cash item | 3.50 | |
| Security coupon collection | 3.50 | |
| Coupon return item | 5.00 | |
| Foreign item | 2.50 | |
| U.S. Treasury and Gov't agency coupons | ([2]) | |
| Check and money order safekeeping | ([2]) | |
| Settlement Agent with Federal Reserve (per active month): | | |
| ACH | 25.00 | |
| Treasury tax and loan | 25.00 | |
| Bond redemption | 25.00 | |
| Currency and coin | 25.00 | |
| Check deposits | 25.00 | |

## DISTRICT 5.—FEDERAL HOME LOAN BANK OF CINCINNATI—(Continued)

| Settlement day option | Par item charge | Earnings incentive (days)* |
|---|---|---|
| Money orders: | | |
| 1—Day | $0.01 | 1.5 |
| 2—Day | .03 | 0 |
| 3—Day | .05 | 0 |
| Tuesday weekly | .09 | 0 |
| Official checks: | | |
| 1—Day | .01 | 2.5 |
| 2—Day | .03 | .75 |

[1] Check deposit fee.
[2] No Charge.
*The earnings incentive is applied to the associations' average daily remittance for the month at the Bank's earnings incentive rate (average 91-Day Treasury Bill Rate plus 10 basis points).

(Note.—The per item fees for disbursements and reconciliation advices do not include printing costs. If the Bank coordinates and pays for the printing of checks, the following printing allowances are assessed: $.055 for money orders; $.045 for dividend checks; $.15 for christmas club checks; $.085 for all other reconciled checks; $.045 for unreconciled checks; and $.02 for reconciliation advices).

## DISTRICT 6.—FEDERAL HOME LOAN BANK OF INDIANAPOLIS

| | Paid check charge | Advices | |
|---|---|---|---|
| | | Paper | Tape |
| Quarterly transaction volume: | | | |
| First 3,750 | $0.13 | $0.05 | $0.025 |
| Next 9,000 | 0.11 | 0.04 | 0.02 |
| Next 12,250 | 0.09 | 0.04 | 0.02 |
| Next 25,000 | 0.08 | 0.03 | 0.015 |
| All over 50,000 | 0.07 | 0.02 | 0.01 |

Overdrafts in excess of $10,000 are assessed a charge at the variable advance rate.
Collected balances will earn at an interest rate that approximates the 91 day Treasury Bill rate.

| Other Services | Metropolitan area | |
|---|---|---|
| | Detroit | Indianapolis |
| Cast item deposited: | | |
| Unencoded | $0.06 | $0.07 |
| Pre-encoded | | 0.04 |
| Return item | 0.75 | 0.75 |
| Photocopies | 2.00 | 2.00 |
| Mortgage remittance:[1] | | |
| Per deposit item received | $0.15 | |
| Truncation of coupons | 0.02 | |

[1] Fee.

Courier charges are assessed for each delivery at various rates depending upon the distances traveled and other cost considerations.
Services charges for the coin and currency program are $25.00 per delivery by armored truck service in the Metropolitan Area of Indianapolis and Detroit while fees vary outside the metropolitan areas depending upon distance involved. Excess funds are picked up if desired.

## DISTRICT 7.—FEDERAL HOME LOAN BANK OF CHICAGO

| Services | Fee | Non-truncated accounts | Truncated accounts |
|---|---|---|---|
| Checks and money orders paid items/month per association: | | | |
| A. Demand accounts: | | | |
| 0 to 7,500 | $.110 | | $.090 |
| 7,501 to 10,000 | .100 | | .080 |
| 10,001 to 12,500 | .090 | | .070 |
| 12,501 to 15,000 | .080 | | .060 |
| 15,001 to 25,000 | .075 | | .055 |
| 25,001 to and up | .070 | | .050 |
| Ancillary services fees: | | | |
| Fine sorting (per item) | | .015 | |
| Recons: | | | |
| Non-encoded items (per item) | | .055 | |
| Encoded items (per item) | | .020 | |
| Magnetic tape items (per item) | | .020 | |
| Stop payments (per stop placed) | | 7.00 | |
| Photocopies (per item) | | 3.00 | |
| Account maintenance (per account per month) | | 10.00 | |
| Additional statements (per statement) | | 5.00 | |
| Checks supplied by bank | | (1) | |
| Request for money order forms | | (2) | |
| Postage/courier | | (2) | |
| ACH services | | (1) | |
| B. Deposit processing checks deposit drawn on: | | | |
| FHLB/Chicago-FHLB Intercept Customers (per item) | | .015 | |
| City of Chicago financial institutions (Routing Numbers 0710, 2710) (per item) | | .030 | |
| Postal money orders (0020, 0119) (per item) | | .030 | |
| U.S. Treasury checks (0050, 0051) (per item) | | .030 | |
| Chicago RCPC financial institutions: (Routing Numbers 0711, 0712, 0719, 2711, 2712, 2719) (per item) | | .053 | |
| Transmit items—Other district financial institutions (per item) | | .084 | |
| Check encoding (per item) | | .035 | |
| Return items: | | | |
| Re-deposits | | (2) | |
| Charge backs (per item) | | 1.00 | |
| Food stamps (per item) | | .02 | |
| Coupons deposits (per envelope) | | 2.50 | |
| Coin and currency Orders (plus costs) | | 2.00 | |
| Visa/Mastercard deposits | | 2.00 | |
| C. Money transfers: | | | |
| Wire transfers: | | | |
| In | | 2.00 | |
| With telephone advice | | 4.00 | |
| Out | | 4.00 | |
| Quick drafts | | 2.00 | |
| Safekeeping: | | | |
| Receipt or delivery: | | | |
| Book entry item | | 10.00 | |
| Physical item | | 10.00 | |
| Coupon collection | | (2) | |
| Collection at maturity | | (2) | |
| Annual maintenance (billed quarterly): | | | |
| Par amount under $5 million | | 80.00 | |
| Par amount $5 million or over (per million) | | 20.00 | |
| Monthly reports | | (2) | |
| Registration fees | | (1) | |

[1] Actual Cost.
[2] No charge.

### District 8.—Federal Home Loan Bank of Des Moines

| Services | Fee |
|---|---|
| Account maintenance | $5.00 |
| Account reconciliation | 5.00 |
| Check printing costs | (1) |
| Drafts Paid: | |
| Truncated | .04 |
| Non-Truncated | .05 |
| Stop payments | 5.00 |
| Ledger credits | .20 |
| Ledger debits | .10 |
| Bankwires in: | |
| Without phone advice | 2.50 |
| With phone advice | 3.50 |
| Bankwires out: | |
| Without phone advice | 4.00 |
| With phone advice | 6.00 |
| Special cut-off statements | 3.00 |
| Account reconciliation tape issues | .02 |
| Issue encoding | .04 |
| Safekeeping transactions | 10.00 |
| Retail repo customers, (per page) plus $25.00 Main. Fee | .25 |
| Food stamps deposited (Des Moines, Kansas City, St. Louis) | .02 |

### District 8.—Federal Home Loan Bank of Des Moines—Continued

| Services | Fee |
|---|---|
| Coupons deposited (per envelope) | 2.50 |
| Microfilm processing | 4.00 |
| Microfilm duplication | 5.00 |
| ACH transaction | (1) |
| Miscellaneous charges | (1) |
| Controlled disbursement drafts | .055 |
| Pre-encoded issues | .03 |
| Proof of deposit fee schedule: | |
| Entry Fee for all items | .003 |
| Re-enter rejects | .04 |
| Encoding fee | .0225 |
| Data transmission (per transmission) | 1.50 |
| Fine sort "on-us" items | .005 |
| Printed reports—Standard (per report) | 1.00 |
| Plus: | |
| (per page) | .05 |
| Optional | (2) |
| plus (per page) | .05 |
| Minimum monthly billing | 40.00 |
| Facsimile Transaction (per transmission) | 1.00 |
| Accout Transaction Info. (per call) | 1.00 |

(1) Actual.
(2) At quotes.

### District 8.—Federal Home Loan Bank of Des Moines

| | Minneapolis | Des Moines | St. Louis | Kansas City |
|---|---|---|---|---|
| Deposited Item Charges: | | | | |
| Local | $.020 | $.025 | $.025 | $.025 |
| Regional | .035 | .035 | .030 | |
| Regional premium | .045 | .04 | .035 | |
| Country | .039 | .0325 | .0375 | |
| Out of State | .075 | .0525 | .065 | .060 |

| | Encoded | Unencoded |
|---|---|---|
| Deposit processing fees/item: | | |
| a. Des Moines Center: | | |
| Local | $.025 | $.0475 |
| Regional | .035 | .0575 |
| Regional—premium | .040 | .0625 |
| Transit | .0525 | .075 |
| b. Minneapolis Center: | | |
| Local | .020 | .0425 |
| Regional | .035 | .0575 |
| Regional—premium | .045 | .0675 |
| Country | .039 | .0615 |
| Transit | .075 | .0975 |
| c. Kansas City Center: | | |
| Local | .0225 | .0450 |
| Country | .0375 | .060 |
| Transit | .060 | .0825 |
| d. St Louis Center: | | |
| Local | .025 | .0475 |
| Regional | .030 | .0525 |
| Regional—premium | .035 | .0575 |
| Country | .035 | .055 |
| Transit | .0650 | .0875 |

| | Fee |
|---|---|
| Other fees at the four regional processing centers: | |
| Return items | $.0175 |
| Food coupons (at Minneapolis only) | .02 |
| Bond coupons (per envelop) | .04 |
| Currency/coin orders | 2.50 |
| Other currency/coin fees | (1) |
| Additional services (St. Louis Center): | |
| Package sort I: | |
| (Pre-encoded items representing 100% or association's daily work): | |
| Local | .0175 |
| Regional | .023 |
| Country | .029 |
| Transit | .065 |
| Package Sort II: | |
| (Pre-encoded items that do not represent 100% of associations's daily work): | |
| Local | .022 |
| Regional | .024 |
| Country | .029 |
| Transit | .065 |
| Package sort III: | |
| (Deposits containing only pre-encoded transit items) | |
| (Items not payable in the St. Louis zone). | |
| Pre-encoded transit items | .07 |

(1) Negotiated.

Note.—A 10% dicount per item on processing fees only is given when monthly volume exceeds 200,000 items. Volume discounts do not apply to any package sort plans.

| Lockbox service | Fee |
|---|---|
| 1. Basic service | $.13 |
| 2. Transmit via user supplied equipment | .01 |
| 3. Transmit via FHLBank supplied equipment | .015 |
| 4. Data prep. for transmission | .04 |
| 5. Re-enter/Reprocess item | .06 |
| 6. Keypunch or MICR encode from handwritten document | .05 |
| 7. Keypunch or MICR encode from pre-printed document | .04 |
| 8. Photocopies | .20 |
| 9. Microfilm copies | 2.75 |
| 10. Storage | N/A |
| 11. Due on sale edit | .005 |
| 12. Write loan account number on check (per item) | .02 |
| 13. Write check number, amount and/or loan number on envelope and return (per item) | .05 |
| 14. Pull selected checks to be non-processed (per item) | .001 |
| 15. Check postmark/sort by date | .001 |
| 16. Call L.B. totals posted (daily) | 1.00 |
| 17. Telephone vertification of account number, etc. (per item) | .50 |
| 18. Process additions to savings or checks accounts | .25 |
| 19. Process additions to principals, escrow, etc. (per item) | .05 |
| 20. Sort and batch envelopes by type or return in sequence (per item) | .001 |
| 21. Batch payments by type in processing (per item) | .001 |
| 22. Process multiple payments (per item) | .001 |
| 23. Process late fees/delinquents, when total amount due not shown (per item) | .001 |
| 24. Process "certified funds required" (per item) | .001 |
| 25. Screen envelope for attention line (per item) | .001 |
| 26. Sort and package output (daily) | 1.00 |
| 27. Date stamp checks, coupons, etc. (per item) | .005 |
| 28. Microfilm checks, coupson, etc. (per item) | .01 |
| 29. Courier/postage | .(1) |
| 30. Post Office box rental | .(1) |
| 31. Local messenger service | .(1) |
| 32. Minimum monthly billing | 40.00 |
| 33. Modified processing; open and screen performed by member | .08 |
| 34. Pull system rejects/hot file rejects (per item) | .02 |
| 35. Update hot file (manual) (per addition) | .50 |
| 36. Update hot file (data transmission) (per addition) | .015 |
| 37. Process payments to hot file (per item) | .004 |

(1) Actual.

### District 9.—Federal Home Loan Bank of Dallas

| Service | Fee (per item) |
|---|---|
| Checks/money orders paid (standard check furnished) | $0.15 |
| Truncation | (1) |
| Reconciliation of check/money order: | |
| Magnetic tape | .02 |
| MICR | .07 |
| Fine sort | .006 |
| Deposits (per check) | .04 |
| Credits/adjustments | (1) |
| Wire: | |
| In | 2.00 |
| Out | 4.00 |
| Check withdrawals | 5.00 |
| Stop payments | 5.00 |
| Exception item return | 2.50 |
| Depository transfer checks | 4.00 |
| Photocopy | 2.50 |
| Transmatic returns | 2.50 |
| Voids | (1) |
| Checks/money order forms (above standard check) | (2) |
| Paid items mailed to association | (2) |
| Overdrafts (per daily occurrence and interest at special variable advance rate plus 3 percent) | 50.00 |

(1) No charge.
(2) Actual costs.

### District 10.—Federal Home Loan Bank of Topeka

| Service | Fee |
|---|---|
| Full service demand plus accounting (includes automatic branch control reconciliation, reporting of full account activity) (per item): | |
| Cycle | $0.15 |
| Truncated | 0.12 |
| Basic demand plus accounting (standard summary statement, must be able to process magnetic tapes) (per item): | |
| Cycle | 0.11 |
| Truncated | 0.08 |
| Wire Transfers: | |
| Incoming (per item) | 2.00 |
| Outgoing (per item) | 4.00 |
| Safekeeping charges and— | |
| Physical securities (per transaction) | 35.00 |
| Wireable securities (per transaction) | 30.00 |
| Pass-through reserves (per month) | 25.00 |

DEPOSIT PROCESSING

| | Topeka | | Oklahoma City | | Kansas City | |
|---|---|---|---|---|---|---|
| | Encoded | Unencoded | Encoded | Unencoded | Encoded | Unencoded |
| Processing fees: | | | | | | |
| Local | $0.025 | $0.038 | $0.025 | $0.038 | $0.038 | $0.0555 |
| RCPC and country | $0.054 | $0.067 | $0.038 | $0.051 | $0.0605 | $0.078 |
| Transit | $0.054 | $0.067 | $0.067 | $0.08 | $0.0605 | $0.078 |

OTHER SERVICES

| | Fee |
|---|---|
| Returns (per item) | $0.80 |
| Collections (per item) | 2.50 |
| Coin and currency (per phone call) | 2.50 |
| Courier and armored car costs | As charged |

DISTRICT 11.—FEDERAL HOME LOAN BANK OF SAN FRANCISCO

| Service | Fee |
|---|---|
| Depository service charges (minimum charge—$300 per month) | |
| Deposit processing: | |
| 5:30 P.M. deposit deadline: | |
| Encoded items deposited: | |
| Mixed (per item) | $.095 |
| Group sort (per item) | .105 |
| Unencoded items deposited: | |
| Mixed (per item) | .110 |
| Group sort (per item) | .120 |
| Deposit ticket (per cash letter) | 1.00 |
| Returned items (per item) | 1.00 |
| Member commercial accounts (per deposit ticket) | 1.00 |
| Wholesale lockbox (contact bank for details) | |
| 10:30 P.M. deposit deadline: | |
| Encoded items deposited (per item) | .05 |
| Unencoded items deposited (per item) | .065 |
| Deposit ticket (per cash letter) | 1.00 |
| Returned items (per item) | 1.00 |
| Member commercial accounts (per deposit ticket) | 1.00 |
| 10:00 A.M. deposit deadline: | |
| Direct deposit of items drawn on financial institutions for whom the Bank serves as in-clearings agent (list furnished upon request) | |
| (Per item) | .01 |
| (Per cash letter) | 1.00 |
| (Per return) | 1.00 |
| Collection services: | |
| Clean collection (per item) | 4.00 |
| Documentary collection (per item) | 10.00 |
| Coupon collection (per envelope) | 6.00 |
| Foreign drafts (per item) | 7.50 |
| Coin and currency: (Pass-through price dependent on: carrier used; association location(s); frequency of delivery/pickup; and volume of coin and currency) | |

DISTRICT 12.—FEDERAL HOME LOAN BANK OF SEATTLE

| Service | Fee |
|---|---|
| Account maintenance (per month) | $3.50 |
| Wire transfers out (per wire) | 3.00 |
| Wire transfer in (per wire) | 2.00 |
| Pre-authorized deposit transfers (per check) | 1.25 |
| Stop payments (per stop) | 3.25 |
| Government recurring payments (per item) | .25 |
| Unreconciled checks paid and fine sorted (per item) | .075 |
| Check paid and reconciled—tape entry (per item) | .065 |
| Check paid and reconciled—register entry (per item) | .095 |
| Check supplies | [1] |

[1] Actual cost.

By the Federal Home Loan Bank Board.

**Jeff Sconyers,**

*Secretary.*

[FR Doc. 85-20791 Filed 8-20-85; 8:45 am]

BILLING CODE 6720-01-M

## FEDERAL MARITIME COMMISSION

### Agreements Filed; Request for Additional Information

Agreement No.: 202-010789.
Title: Israel Westbound Conference.
Agreement No.: 202-010790.
Title: Israel Eastbound Conference.
Parties: Zim Israel Navigation Co., Ltd.; Farrell Lines, Inc.; Lykes Bros, Steamship Company, Inc.

Synopsis: Notice is hereby given that the Federal Maritime Commission, pursuant to section 6A(d) of the Shipping Act of 1984 (46 U.S.C. app. 1701-1720), has requested additional information from the parties to the agreements in order to complete the statutory review of Agreements Nos. 202-010789 and 202-010790 as required by the Act. This section extends the review period as provided in section 6(c) of the Act.

By Order of the Federal Maritime Commission.

Dated: August 23, 1985.

**Bruce A. Dombrowski,**

**Acting Secretary.**

[FR Doc. 85-20933 Filed 8-30-85; 8:45 am]

BILLING CODE 6730-01-M

## FEDERAL RESERVE SYSTEM

### Agency Forms Under OMB Review

August 28, 1985.

### Background

On June 15, 1984, the Office of Management and Budget (OMB) delegated to the Board of Governors of the Federal Reserve System (Board) its approval authority under the Paperwork Reduction Act of 1980, as per 5 CFR §1320.9, "to approve of and assign OMB control numbers to collection of information requests and requirements conducted or sponsored by the Board under conditions set forth in 5 CFR §1320.9." Board-approved collections of information will be incorporated into the official OMB inventory of currently approved collections of information. A copy of the SF 83 and supporting statement and the approved collection of information instrument(s) will be placed into OMB's public docket files. The following forms, which are being handled under this delegated authority, have received initial Board approval and are hereby published for comment. At the end of the comment period, the proposed information collection, along with an analysis of comments and recommendations received, will be submitted to the Board for final approval under OMB delegated authority.

**DATE:** Comments must be received within fifteen working days of the date of publication in the **Federal Register.**

**ADDRESS:** Comments, which should refer to the OMB Docket number (or Agency form number in the case of a new information collection that has not yet been assigned an OMB number), should be addressed to Mr. William W. Wiles, Secretary, Board of Governors of the Federal Reserve System, 20th and C Street, N.W., Washington, D.C. 20551, or delivered to room B-2223 between 8:45 a.m. and 5:15 p.m. Comments received may be inspected in room B-1122 between 8:45 a.m. and 5:15 p.m., except as provided in §261.6(a) of the Board's Rules Regarding Availability of Information, 12 CFR 261.6(a).

A copy of the comments may also be submitted to the OMB desk officer for the Board: Robert Neal, Office of Information and Regulatory Affairs, Office of Management and Budget, New Executive Office Building, Room 3208, Washington, D.C. 20503.

**FOR FURTHER INFORMATION CONTACT:** A copy of the proposed form, the request for clearance (SF 83), supporting statement, instructions, and other documents that will be placed into OMB's public docket files once approved may be requested from the agency clearance officer, whose name appears below.

Federal Reserve Board Clearance Officer—Cynthia Glassman—Division of Research and Statistics, Board of Governors of the Federal Reserve System. Washington, D.C. 20551 (202-452-3822)

*Proposal to approve under OMB delegated authority the implementation of the following report:*

1. Report title: One-Time Survey of Foreign Transactions of Primary Dealers
Agency form number: FR 3035
OMB Docket number: 7100-0214

Frequency: One-Time
Reporters: U.S. Government Securities Dealers
Small businesses are not affected.

General description of report:

This information collection is voluntary (12 U.S.C. 248a(2) and 353 et seq.) and is given confidential treatment (5 U.S.C. 552(b)(4)).

This report will provide information on the foreign activity of the 36 primary U.S. Government securities dealers over a period of one month. The information will be used to gauge the magnitude of foreign transactions and to gain some insight into their composition.

Board of Governors of the Federal Reserve System, August 28, 1985.

**James McAfee,**

*Associate Secretary of the Board.*

[FR Doc. 85-20902 Filed 8-30-85; 8:45 am]

BILLING CODE 6210-01-M

## First Indiana Bancorp, et al.; Formations of, Acquisitions by, and Mergers of Bank Holding Companies

The companies listed in this notice have applied for the Board's approval under section 3 of the Bank Holding Company Act (12 USC 1842) and § 225.14 of the Board's Regulation Y (12 CFR 225.14) to become a bank holding company or to acquire a bank or bank holding company. The factors that are considered in acting on the applications are set forth in section 3(c) of the Act (12 U.S.C. 1842(c)).

Each application is available for immediate inspection at the Federal Reserve Bank indicated. Once the application has been accepted for processing, it will also be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing to the Reserve Bank or to the offices of the Board of Governors. Any comment on an application that requests a hearing must include a statement of why a written presentation would not suffice in lieu of a hearing, identifying specifically any questions of fact that are in dispute and summarizing the evidence that would be presented at a hearing.

Unless otherwise noted, comments regarding each of these applications must be received not later than September 25, 1985.

A. Federal Reserve Bank of Chicago (Franklin D. Dreyer, Vice President) 230 South LaSalle Street, Chicago, Illinois 60690:

1. *First Indiana Bancorp,* Elkhart, Indiana; to merge with Syracuse Bancorp, Inc., Syracuse, Syracuse, Indiana, thereby indirectly acquiring State Bank of Syracuse, Indiana.

2. *First State Bancorp of Monticello,* Monticello, Illinois; to acquire 100 percent of the voting shares of Prairie State Bank, Bloomington, Illinois.

3. *First Wisconsin Corporation,* Milwaukee, Wisconsin; to acquire 100 percent of the voting shares of Security Financial Services, Inc., Sheboygan, Wisconsin, thereby indirectly acquiring the following banks: Security First National Bank of Sheboygan, Sheboygan; South-West State Bank, Sheboygan; Farmers-Merchants National Bank in Princeton, Princeton; Eldorado State Bank, Eldorado; Security Bank, Menasha; and Manitowoc County Bank, Manitowoc, all located in Wisconsin. Comments on this application must be received not later than September 20, 1985.

Board of Governors of the Federal Reserve System, August 27, 1985.

**James McAfee,**

*Associate Secretary of the Board.*

[FR Doc. 85-20901 Filed 8-30-85; 8:45 am]

BILLING CODE 6210-01-M

**[Docket No. R-0515]**

## Interpretation

**AGENCY:** Board of Governors of the Federal Reserve System.

**ACTION:** Interpretation.

**SUMMARY:** On May 17, 1985 (50 FR 21120; May 22, 1985), the Board issued a policy statement regarding risks on large-dollar wire transfer systems urging, among other things, that institutions participating on large-dollar wire networks adopt sender net debit caps. The Board has now taken steps to provide depository institutions and Edge corporations an additional option in sender net debit cap determination. Specifically, such institutions may have their sender net debit cap levels reviewed and established by either their own board of directors or by the board of a higher level corporation within its corporate family. If the new second option is selected, certain conditions (indicated below) must be met.

**FOR FURTHER INFORMATION CONTACT:** Edward C. Ettin, Deputy Director, Division of Research and Statistics (202-452-3368); Joseph R. Alexander, Attorney, Legal Division (202-452-2489); or Joy W. O'Connell, Telecommunication Device for the Deaf, TDD (202-452-3244).

**SUPPLEMENTARY INFORMATION:** The Board of Governors has issued the following interpretation of its policy statement concerning risk on large-dollar wire transfer systems:

Under the policy adopted by the Board in May, each depository institution and Edge Act and agreement corporation that incurs daylight overdrafts on Fedwire or participates on a large-dollar wire transfer network is encouraged to establish a cross-system sender net debit cap. In establishing this cap, each institution and Edge or agreement corporation was to (1) conduct its own self-evaluation of its creditworthiness, operational policies and procedures, and credit policies; (2) present the self-evaluation to that entity's board of directors for review and approval each six months; and (3) maintain for its primary examiner a file containing that self-evaluation and board review, the resultant cap level, and other materials which the examiner would review periodically, at least at each examination.

Since the Board's policy was announced, the Board has received several requests to allow an institution's sender net debit cap to be reviewed and approved by the board of directors of a parent organization. In one case, a bank has requested that its board of directors be permitted to review the cap determination of its Edge corporation subsidiary because the Edge's board does not meet every six months. Another bank that is a subsidiary of a multi-bank holding company has requested, in the name of efficiency, that the board of the holding company be permitted to review the cap determination of each of the subsidiary banks.

The Board believes that these requests are reasonable and has determined that a depository institution has the option of either having its own board of directors review its self-evaluation and determine its cap or having the board of directors of its parent holding company or parent bank review and approve its self-evaluation and cap, provided that (1) the self-evaluation be performed by each entity incurring daylight overdrafts or participating on a private large-dollar network; (2) the entity's cap be based on the entity's own capital (adjusted to avoid double counting); and (3) each entity maintain for its primary supervisor's review its own file with supporting documents for its self-evaluation and a record of its own or high level board of directors' review.

By order of the Board of Governors of the Federal Reserve System, August 27, 1985.

**James McAfee,**

*Associate Secretary of the Board.*

[FR Doc. 85-20903 Filed 8-30-85; 8:45 am]

BILLING CODE 6210-01-M

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Statement of Organization, Functions and Delegations of Authority; Social Security Administration

Part S of the Statement of Organization, Functions and Delegations of Authority for the Department of Health and Human Services (DHHS) covers the Social Security Administration (SSA). This material is amended to reflect the consolidation of various responsibilities associated with SSA's comprehensive systems planning and support processes for Information Technology Systems (ITS). This consolidation improves organizational effectiveness by merging all ITS planning and supporting functions into one component, a new Office of Planning, Support and Integration (OPSI), which reports through the Deputy Commissioner for Systems, to the Commissioner of Social Security. The functions currently assigned to the Strategic Planning Staff (SUB) of the Office of System Integration (OSI) (as published in 48 FR 341 on January 4, 1983), the Systems Security Staff (SUH2) of the OSI Office of System Engineering (OSE) (as published in 48 FR 36907 on August 15, 1983), and the Office of Systems Management (SQ) (as published in 49 FR 21121 on May 18, 1984) are realigned to the new OPSI, and the three organizations in which they now reside (SUB, SUH2 and SQ as noted above) are abolished.

To effect this consolidation of support and planning functions into OPSI, the following changes are made to Part S:

Chapter S, Section S.10 *The Social Security Administration*—(Organization):

Change the title of Subsection U. The Office of Systems Management (SQ) to read as follows:

U. *The Office of Planning, Support and Integration (SQ).*

Chapter SU, Section SU.00 *The Office of System Integration*—(Mission):

Delete the entire first paragraph lines 1 through 8 in their entirety.

Section SU.10 *The Office of System Integration*—(Organization):

Delete E. The Strategic Planning Staff (SUB).

Reletter remaining Subsections E through H.

Subsection I *The Office of System Engineering (SUH)*

Delete number 2 The Systems Security Staff in its entirety (SUH2).

Renumber remaining Subsections 2 through 5.

Section SU.20 *The Office of System Integration*—(Functions):

Delete in its entirety:

E. The Strategic Planning Staff (SUB).

Reletter remaining Sections E through H.

Subsection I *The Office of System Engineering (SUH)*

Delete number 2 The Systems Security Staff in its entirety (SUH2).

Renumber remaining Subsections 2 through 5.

Chapter SO, *Office of Systems Management*

Delete this chapter in its entirety. In its place, add the new

Chapter SO, *Office of Planning, Support and Integration* as follows:

Section SO.00 *The Office of Planning, Support and* Integration—(Mission):

The Office of Planning Support and Integration (OPSI) directs and conducts SSA's comprehensive integration and strategic planning processes. OPSI analyzes Systems Modernization Plan (SMP) program strategies and coordinates the integration of SMP program interdependencies, critical paths and major milestones. OPSI analyzes strategic systems requirements, identifies systems design and architectural implications and maintains the design integrity of both software and systems engineering efforts SSA-wide. OPSI develops SSA's ITS budget, prepares the SSA Systems detailed budget submission and develops and maintains systems-wide procurement, contract and resource monitoring and tracking systems. OPSI directs the design, development and maintenance of automated systems and processes for the SSA Systems Management Center (SMC) in support of systems management and integration responsibilities. OPSI develops and monitors systems security policy for the SSA systems organization. The Office provides SSA's focal point for Information Resource Management (IRM) activities and liaison with the Department of Health and Human Services. OPSI identifies administrative and technical training requirements and integrates these with the Office of Training, Office of Management, Budget and Personnel. OPSI analyzes systems organizational issues and concerns and provides support to the Commissioner, the Deputy Commissioner for Systems, and Associate Commissioners in the development of plans to accomplish needed changes.

Section SQ.10 *The Office of Planning, Support and Integration*—(Organization):

The Office of Planning, Support and Integration under the leadership of the Director includes:

A. Office of the Director for Planning, Support and Integration (SQ).

Section SQ.20 *The Office of Planning, Support and Integration*—(Functions):

A. The Director, Office of Planning, Support and Integration (SQ), is directly responsible to the Commissioner through the Deputy Commissioner, Systems, for carrying out the OPSI mission and providing general supervision to the major components of OPSI.

Dated: August 22, 1985.

**Margaret M. Heckler,**

*Secretary of Health and Human Services.*

[FR Doc. 85-20954 Filed 8-30-85; 8:45 am]

BILLING CODE 4110-07-M

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### Statement of Organization, Functions and Delegations of Authority; Social Security Administration

Part S of the Statement of Organization, Functions and Delegations of Authority for the Department of Health and Human Services (DHHS) covers the Social Security Administration (SSA). Sections SD.00, SD.10 and SD.20 of the SSA statement, as published in the **Federal Register** on November 13, 1981 (46 FR 56055–56056), describes the mission, organization and functions of SSA's Office of Field Operations. Notice is given that these sections are being abolished.

Sections SDB.00, SDB.10 and SDB.20 of the SSA statement, as published in the **Federal Register** of September 10, 1979 (44 FR 52756–52757), and amended on June 11, 1980 (45 FR 39542–44), November 13, 1981 (46 FR 56055–56056) and June 1, 1983 (48 FR 24460), describe the mission, organization and functions of SSA's Office of the Regional Commissioner (ORC). Notice is given that these sections are being redesignated as Sections SD.00, SD.10 and SD.20, and that the reporting relationship of the ORC is being changed. Revise the SSA material as follows:

1. Abolish the current SD sections in their entirety.

2. Redesignate Chapter SDB as Chapter SD.

3. Under the redesignated Section SD.20 *The Offices of the Regional Comission*—(Functions):

A. Should read as follows: The Regional Commissioners (SDI–SDX) are directly responsible to the Commissioner, SSA for carrying out ORC's mission and managing their respective SSA regional organizations.

Dated: August 22, 1985.

Margaret M. Heckler,

*Secretary of Health and Human Services.*

[FR Doc. 85-20953 Filed 8-30-85; 8:45 am]

BILLING CODE 4190-07-M

## Statement of Organization, Functions and Delegations of Authority; Social Security Administration

Part S of the Statement of Organization, Functions and Delegations of Authority for the Department of Health and Human Services (DHHS) covers the Social Security Administration (SSA). Notice is given that Chapter SA, as published in the Federal Register on March 21, 1979 (44 FR 17219) and last amended in February 9, 1984 (49 FR 4989) is amended to add the Field Liaison and Support Staff (FLSS). The new material is as follows: Section SA.10 *The Office of the Commissioner*—(Organization):

Add: Subsection F3. Field Liaison and Support Staff (SAY) Section SA.20 *The Office of the Commissioner*—(Functions):

Under Subsection F add:

3. Field Liaison and Support Staff (SAY)

a. Advises the Commissioner and his/her Executive Staff on the full range of issues pertaining to headquarters' support to the SSA field organization.

b. Ensures effective ongoing liaison between SSA headquarters and the SSA field organization.

c. Ensures that the concerns of and issues raised by the field organization on proposed legislation, operations, policy, procedures and systems matters are addressed by the appropriate headquarters' components.

d. Coordinates with field management in the identification of field components' systems needs, and in the installation and evaluation of systems applications in all SSA programs which affect field office operating procedures and practices.

e. Plans and coordinates a continuing program of operational analysis throughout field operations and the design and implementation of studies to measure the overall effectiveness and efficiency of field operations processes and identification and resolution of operating problems and issues.

Dated: August 22, 1985.

Margaret M. Heckler,

*Secretary of Health and Human Services.*

[FR Doc. 85-20952 Filed 8-30-85; 8:45 am]

BILLING CODE 4110-07-M

## Departmental Grant Appeals Board; Delegation of Authority

Notice is hereby given that on August 6, 1985, the Secretary of Health and Human Services delegated to any and all Administrative Law Judges in or assigned or detailed to the Departmental Grant Appeals Board authority under sections 1128(e), 1128A(b), 1872, and 1918 of the Social Security Act, as amended, to conduct hearings and to render decisions with respect to the imposition of civil money penalties and/or assessments under section 1128A(a) and the suspensions from Medicare under section 1128(c) of the Social Security Act. The delegation includes, but is not limited to, the authority to administer oaths and affirmations, to issue subpoenas, to examine witnesses, to receive evidence, and to make determinations to impose penalties and/or assessments and suspensions, which will be final unless reviewed by the Secretary or her designee in accordance with regulations.

The delegation rescinded the earlier delegation of these authorities to the Chairman of the Departmental Grant Appeals Board, dated December 13, 1983.

Dated: August 23, 1985.

John J. Shaughnessy,

*Assistant Secretary for Management and Budget.*

[FR Doc. 85-20951 Filed 8-30-85; 8:45 am]

BILLING CODE 4150-04-M

## Food and Drug Administration

[Docket No. 83N-0260]

## Dental X-Ray Patient Selection Criteria Panel; Meeting

**AGENCY:** Food and Drug Administration.

**ACTION:** Notice.

**SUMMARY:** The Food and Drug Administration (FDA) is announcing a forthcoming meeting of the Dental X-Ray Patient Selection Criteria Panel. This is the fourth meeting of the Panel. The meeting is being called to discuss the review comments received on the Panel's draft report entitled, "The Selection of Patients for Dental X-Ray Examinations: Routine Dental X-Ray Examinations."

**DATES:** Open sessions: September 11, 8:30 a.m. to 9 a.m., and September 12, 8:30 a.m. to 9 a.m.; closed sessions: September 11, 9 a.m. to 5 p.m., and September 12, 9 a.m. to 4 p.m.

**ADDRESSES:** The Panel meeting will be held at the Cascades Conference Center, Williamsburg, VA, 804-229-1000. The Panel's draft report may be reviewed at the Dockets Management Branch (HFA-305), Food and Drug Administration, Rm. 4-62, 5600 Fishers Lane, Rockville, MD 20857.

**FOR FURTHER INFORMATION CONTACT:** Lireka P. Joseph, Center for Devices and Radiological Health (HFZ-250), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301-443-4600.

**SUPPLEMENTARY INFORMATION:** Through the Center for Devices and Radiological Health, FDA conducts and supports research, training, and other activities to minimize unproductive radiation exposure from diagnostic radiological examinations. One possible source of unproductive radiation exposure is radiological examinations that are not likely to affect patient management. To reduce the use of ineffective examinations, it is important that the dentist have current information about when a given radiological study is likely to provide needed diagnostic information. This information can take the form of decision guidelines based on patient signs, symptoms, or history, sometimes known as patient selection criteria.

Under one part of a program designed to facilitate the development and testing by the dental profession of patient selection criteria for diagnostic radiological examinations, FDA has provided logistical support for the convening of a small panel of clinical and scientific experts that have formulated patient selection criteria statements of use. A detailed description of the x-ray referral criteria development process was published in the Federal Register of June 9, 1981 (46 FR 30568).

The Panel's recommendations on the selection of patients for dental x-ray examinations are incorporated in a draft report entitled, "The Selection of Patients for Dental X-Ray Examinations: Routine Dental X-Ray Examinations." The availability of this draft report was announced in the Federal Register of July 19, 1985 (50 FR 29483). The Panel is now convening to discuss and review the comments received concerning the draft report. If through the review process new data provide sufficient and necessary argument to warrant changes in the recommendations, the Panel will consider them at this meeting.

Any interested person who wishes to request time for an oral presentation during the open portion of the meeting, or who would like to submit written comments to the Panel and is unable to attend the open portion of the meeting,

should inform the contact person listed above, either orally or in writing, before the meeting. Persons attending the meeting who do not request time for an oral presentation will be permitted to make an oral presentation at the conclusion of the open portion if time permits.

A list of committee members, the meeting agenda, summaries of the previous Panel meetings, the draft report, and comments received on the draft report may be reviewed at the Dockets Management Branch (address above), between 9 a.m. and 4 p.m., Monday through Friday. The summaries of the Panel meetings will contain minutes of the open sessions, copies of written data and views submitted to the Panel in the open sessions, and summaries of the closed sessions.

Dated: August 22, 1985.

**Mervin H. Shumate,**

*Acting Associate Commission for Regulatory Affairs.*

[FR Doc. 85-20934 Filed 8-28-85; 2:09 pm]

BILLING CODE 4160-01-M

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## Small Business Participation; Open Meeting

**AGENCY:** Food and Drug Administration.

**ACTION:** Notice.

**SUMMARY:** The Food and Drug Administration (FDA) announces a forthcoming small business exchange meeting to be chaired by E. Pitt Smith, Director, Buffalo District Office.

**DATE:** The meeting will be held at 1 p.m., Thursday, September 26, 1985.

**ADDRESS:** The meeting will be held at the Leo W. O'Brien Federal Bldg., Conference Rm. B38 A and B, Clinton & North Pearl Sts., Albany, NY 12207.

**FOR FURTHER INFORMATION CONTACT:** George R. Walden, Small Business Representative, Food and Drug Administration, 20 Evergreen Pl., East Orange, NJ 07018-2195, 201-645-6466.

**SUPPLEMENTARY INFORMATION:** The purpose of this meeting is to encourage dialogue between small business and FDA officials. The meeting will provide a forum for the owners and managers of small businesses to express their concerns about FDA, encourage discussion about the effects of regulation and regulatory alternatives, convey knowledge about the agency's operations and procedures, and increase participation by small business persons in FDA's decisionmaking process.

Dated: August 27, 1985.

**Mervin H. Shumate,**

*Acting Associate Commissioner for Regulatory Affairs.*

[FR Doc. 85-20935 Filed 8-28-85; 2:08 pm]

BILLING CODE 4160-01-M

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## Health Care Financing Administration

[BERC-278-CN]

## Medicare Program; Schedule of Limits on Home Health Agency Costs per Visist for Cost Reporting Periods Beginning on or After July 1, 1985

**AGENCY:** Health Care Financing Administration (HCFA), HHS.

**ACTION:** Correction of final notice.

**SUMMARY:** This document corrects technical errors that appeared in the final notice published July 5, 1985 which set forth a schedule of limits on home health agency (HHA) costs that may be reimbursed under the Medicare program. This document also lists three new metropolitan statistical area (MSA) designations that were announced by the Executive Office of Management and Budget (EOMB) and inadvertently omitted from that final notice.

**FOR FURTHER INFORMATION CONTACT:** Michael Notzon, (301) 597-6334.

**SUPPLEMENTARY INFORMATION:** We stated in the final notice published in the **Federal Register** on July 5, 1985 (50 FR 27734) that if EOMB were to announce changes in the MSA designations before July 1, 1985, we would recalculate the wage indexes for the affected areas and direct our intermediaries to use these revised indexes in determining the limits for HHAs they service. While the document was in the final clearance process, EOMB announced in a press release on June 27, 1985 (OMB 85-18) that, based on recent Bureau of the Census population data, effective June 30, 1985, OMB would be recognizing three new MSAs (Cheyenne, Wyoming; Jackson, Tennessee; and Rapid City, South Dakota). Inadvertently, however, the new MSAs were not added to the list in the July 5, 1985 publication. Therefore, we have included the new MSAs and their corresponding wage index values in this correction notice, along with other corrections of technical errors for that document. We have also recalculated the rural wage index values for Wyoming, Tennessee, and South Dakota to reflect the inclusion of previously rural counties in the new MSAs.

In FR Doc. 85-15965, beginning on page 27734 in the issue of Friday, July 5, 1985, make the following corrections:

A. *Page 27741, Column 1*

In the table, the column titled "Percent Increase", the superscript for 1984, "2," is corrected to "1".

B. *Page 27742*

1. In column 3, in Table IIIA, titled "Wage Index for Urban Areas", the wage index value for Allentown-Bethlehem, PA-NJ, "1.6017", is corrected to "1.0617."

2. In column 3, the wage index value for Atlanta, GA, ".9733", is corrected to ".9728."

C. *Page 27743*

1. In column 1, the wage index value for Bergen-Passaic, NJ, "1.0181", is corrected to "1.0184."

2. In column 1, the wage index value for Bloomington, IN, ".9185", is corrected to ".9171."

3. In column 2, the wage index value for Bremerton, WA, ".9434", is corrected to ".9562."

4. In column 2, a new MSA and its wage index value is inserted between the MSA entries for Chattanooga, TN-GA and Chicago, IL, reading as follows:

"Cheyenne, WY ..... 9914
Laramie, WY"

5. In column 3, the wage index value for Denver, CO, "1.0024", is corrected to "1.1875."

6. In column 3, the wage index value for Detroit, MI, "1.1661", is corrected to "1.1681."

D. *Page 27744*

1. In column 1 the wage index value for Grand Forks, ND, ".9576", is corrected to ".9796."

2. In column 2, the wage index value for Jackson, MI, "1.0062", is corrected to "1.0400."

3. In column 2, a new MSA and its wage index value is inserted between the MSA entries for Jackson, MS and Jacksonville, FL, reading as follows:

"Jackson, TN ..... 8180
Madison, TN"

4. In column 2, the wage index value for Janesville-Beloit, WI, ".9504", is corrected to ".9042."

5. In column 2, the wage index value for Johnson City-Kingsport-Bristol, TN-VA, ".9362", is corrected to ".9308."

6. In column 2, the wage index value for Kansas City, MO-KS, "1.0475", is corrected to "1.0451."

7. In column 3, the wage index value for Lansing-East Lansing, MI, "1.0469", is corrected to "1.0460."

8. In column 3, the wage index value for Lawrence, KS, "[1].9409", is corrected to ".9404[1]."

9. In column 3, the wage index value for Lincoln, NE, ".7913", is corrected to ".9171."

E. *Page 27745*

1. In column 1, the wage index value for Muncie, IN, ".9223", is corrected to ".9923."

2. In column 1, the wage index value for New Orleans, LA, "1.0186", is corrected to "1.0184."

3. In column 2, the wage index value for Ocala, FL, "[1].9658, is corrected to ".9666[1]."

4. In column 2, the wage index value for Odessa, TX, "[1] 1.0457", is corrected to "1.0451 [1]."

5. In column 2, the wage index value for Omaha, NE–IA, ".9622", is corrected to ".9667."

6. In column 3, a new MSA and its wage index value is inserted between the MSA entries for Raleigh-Durham, NC and Reading, PA, reading as follows:

"Rapid City, SD.....8823
Pennington, SD"

F. *Page 27746*

1. In column 2, the wage index value for Topeka, KS, "1.1128", is corrected to "1.1129."

2. In column 3, the wage index value for Colorado, ".8656", is corrected to ".8619."

3. In column 3, the wage index value for Georgia, ".8306", is corrected to ".8305."

4. In column 3, the wage index value for Illinois, ".8915", is corrected to ".8911."

5. In column 3, the wage index value for Louisiana, ".8623", is corrected to ".8626."

6. In column 3, the wage index value for Michigan, ".9362" is corrected to ".9349."

7. In column 3, the wage index value for Nebraska, ".7258", is corrected to ".7345."

G. *Page 27747*

1. In column 1, the wage index value for Rhode Island, "[1].9328", is corrected to ".9306 [1]."

2. In column 1, the wage index value for South Dakota, ".7621", is corrected to ".7437."

3. In column 1, the wage index value for Tennessee, ".7768", is corrected to ".7709."

4. In column 1, the wage index value for Wyoming, ".9658", is corrected to ".9613."

(Sec. 1102, 1861(v) and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x(v) and 1395hh)

(Catalog of Federal Domestic Assistance Program No. 13.773, Medicare-Hospital Insurance)

Dated: August 23, 1985.

**K. Jacqueline Holz,**

*Deputy Assistant Secretary for Management Analysis and Systems.*

[FR Doc. 85–20956, Filed 8–30–85; 8:45 am]

BILLING CODE 4120–03–M

## DEPARTMENT OF THE INTERIOR

### Bureau of Land Management

[N–1881]

### Classification Vacated; Correction; Nevada

August 21, 1985.

In FR Doc 83–19364 issued Tuesday, July 19, 1983, third column, para numbered 4, the land description should read

T. 1 N., R. 33 E.,
Sec. 5, SW¼SW¼;
Sec. 8, N½NW¼NW¼.

**Edward F. Spang,**

*State Director, Nevada.*

[FR Doc. 85–20960 Filed 8–30–85; 8:45 am]

BILLING CODE 4310–HC–M

## National Park Service

### National Register of Historic Places, Alabama, et al.; Notification of Pending Nominations

Nominations for the following properties being considered for listing in the National Register were received by the National Park Service before September 3, 1985. Pursuant to § 60.13 of 36 CFR Part 60 written comments concerning the significance of these properties under the National Register criteria for evaluation may be forwarded to the National Register, National Park Service, U.S. Department of the Interior, Washington, DC 20243. Written comments should be submitted by September 18, 1985.

**Bruce MacDougal,**

*Acting Chief of Registration, National Register.*

**ALABAMA**

**Calhoun County**

Anniston, *Addie, Glen, Volunteer Hose Company Fire Hall (Anniston MRA)*, Forth St. & Pine Ave.
Anniston, *Anniston Cotton Manufacturing Company (Anniston MRA)*, 215 W. Eleventh St.
Anniston, *Bagley—Cater Building (Anniston MRA)*, 15 E. Tenth St.
Anniston, *Bank of Anniston (Anniston MRA)*, 1005 Noble St.
Anniston, *Calhoun County Courthouse (Anniston MRA)*, 25 W. Eleventh St.
Anniston, *Glenwood Terrace Residential Historic District (Anniston MRA)*, Roughly bounded by Oak St., Jefferson Ave., lots on S. side of Glenwood Terr. & N. side of Orchard St. and Highland Ave.
Anniston, *Glover, Henry Burt, House (Anniston MRA)*, 1119 Leighton Ave.
Anniston, *Grace Episcopal Church (Anniston MRA)*, 1000 Leighton Ave.
Anniston, *Hill Cemetery (Anniston MRA)*, Highland Ave. between Tenth & Eleventh Sts.
Anniston, *Huger, Richard P., House (Anniston MRA)*, 1901 Wilmer Ave.
Anniston, *Kilby House (Anniston MRA)*, 1301 Woodstock Ave.
Anniston, *Kress Building (Anniston MRA)*, 1106 Noble St.
Anniston, *Montgomery Ward—Alabama Power Company Building (Anniston MRA)*, 1201 Noble St.
Anniston, *Mount Zion Baptist Church (Anniston MRA)*, 212 Second St.
Anniston, *Noble, Samuel, Monument (Anniston MRA)*, Eleventh St. & Quintard Ave.
Anniston, *Noble—McCoo—Butler House (Anniston MRA)*, 1025 Fairmont Ave.
Anniston, *Nonnenmacher Bakery (Anniston MRA)*, 36 W. Eleventh St.
Anniston, *Nonnenmacher House (Anniston MRA)*, 1311 Gurnee Ave.
Anniston, *Oak Tree Cottage (Anniston MRA)*, 721 Oak St.
Anniston, *Parker Memorial Baptist Church (Anniston MRA)*, 1205 Quintard Ave.
Anniston, *Peerless Saloon (Anniston MRA)*, 13 W. Tenth St.
Anniston, *Rollstone Machinery Company (Anniston MRA)*, 300 W. Fifteenth St.
Anniston, *Saint Paul's Methodist Episcopal Church (Anniston MRA)*, 1327 Leighton Ave.
Anniston, *Security Bank Building (Anniston MRA)*, 1030 Noble St.
Anniston, *Smith, Lansing T., House (Anniston MRA)*, 531 Keith Ave.
Anniston, *Temple Beth-El (Anniston MRA)*, 301 E. Thirteenth St.
Anniston, *Tyler Hill Residential Historic District (Anniston MRA)*, Roughly bounded by E. Seventh & E. Sixth Sts. and Lapsley, Goodwin & Leighton Aves.
Anniston, *Union Depot and Freight House (Anniston MRA)*, 1300 Walnut Ave.
Anniston, *Wikle Drug Company (Anniston MRA)*, 1010 Noble St.

**ARIZONA**

**Maricopa County**

Phoenix, *Durand Grocery (Phoenix Commercial TR)*, 901 Grand Ave.
Phoenix, *Firestone (Phoenix Commercial TR)*, 302 W. Van Buren
Phoenix, *Higuera Grocery (Phoenix Commercial TR)*, 923 S. Second Ave.
Phoenix, *Overland Arizona Co. (Phoenix Commercial TR)*, 12 N. Forth Ave.
Phoenix, *Rehbein Grocery (Phoenix Commercial TR)*, 1231 Grand Ave.
Phoenix, *Valley Plumbing & Sheet Metal (Phoenix Commercial TR)*, 530 W. Adams.
Phoenix, *West End Hotel (Phoenix Commercial TR)*, 701 W. Washington

**Montezuma County**

*Surouaro*

MASSACHUSETTS

Bristol County

North Attleborough, *North Attleborough Town Center Historic District*, Bank, Bruce, Church, Grove & Mason Aves. and N. & S. Washington Sts.

Essex County

Peabody, *Hickey—Osborne Block*, 38–60 Main St.

MICHIGAN

Gratiot County

*Brown Site (20GR21)*

MONTANA

Sweetgrass County

Big Timber, *Grand Hotel*, 139 McLeod St.

NEW JERSEY

Ocean County

Island Heights, *BAT (catboat) (Barnegat Bay Class A racing catboats 1922–1925 TR)*

NEW YORK

Albany County

Colonie, *Bacon—Stickney House (Colonie Town MRA)*, 441 Loudon Rd.
Colonie, *Byrne, Senator William T., House (Colonie Town MRA)*, 463 Loudon Rd.
Colonie, *Cramer, Frederick, House (Colonie Town MRA)*, 410 Albany-Shaker Rd.
Colonie, *Dunsbach, Martin, House (Colonie Town MRA)*, 140 Dunsbach Ferry Rd.
Colonie, *Fuller, Royal K., House (Colonie Town MRA)*, 294 Loudon Rd.
Colonie, *Haswell, Isaac M., House (Colonie Town MRA)*, 67 Haswell Rd.
Colonie, *Hedge Lawn (Colonie Town MRA)*, 592 Broadway
Colonie, *Henry—Remsen House (Colonie Town MRA)*, 34 Spring St.
Colonie, *Hills, Ebenezer, Jr., Farmhouse (Colonie Town MRA)*, 1010 Troy-Schenectady Rd.
Colonie, *Humphrey, Friend, House (Colonie Town MRA)*, 372 Albany-Shaker Rd.
Colonie, *Kemp, John Wolf, House (Colonie Town MRA)*, 216 Wolf Rd.
Colonie, *Lansing, John V.A., Farmhouse & Billsen Cemetery and Archaeological Site (Colonie Town MRA)*, 219, 225 & 237 Consaul Rd.
Colonie, *Lawton, George H., House (Colonie Town MRA)*, 27 Maxwell Rd.
Colonie, *Menand Park Historic District (Colonie Town MRA)*, Roughly bounded by Menand Rd., Broadway & Tillinghast Ave.
Colonie, *Menand, Louis, House (Colonie Town MRA)*, 40 Cemetery Ave.
Colonie, *Menands Manor (Colonie Town MRA)*, 272 Broadway
Colonie, *Pruyn, Casparus F., House (Colonie Town MRA)*, 207 Old Niskayuna Rd.
Colonie, *Reformed Dutch Church of Rensselaer in Watervliet (Colonie town MRA)*, 210 Old Loudon Rd.
Colonie, *Renshaw, Alfred H., House (Colonie Town MRA)*, 33 Fiddlers Lane
Colonie, *Simmons Stone House (Colonie Town MRA)*, 554 Boght Rd.
Colonie, *Strong, Jedediah, House (Colonie Town MRA)*, 379 Vly Rd.
Colonie, *Treemont Manor (Colonie Town MRA)*, 71 Old Niskayuna Rd.
Colonie, *Trimble, George, House (Colonie Town MRA)*, 158 Spring Street Rd.
Colonie, *Van Denbergh—Simmons House (Colonie Town MRA)*, 537 Boght Rd.
Colonie, *Verdoy School (Colonie Town MRA)*, 957 Troy-Schenectady Rd.

Monroe County

Rochester, *Brown, Adam, Block (Inner Loop MRA)*, 480 E. Main St.
Rochester, *Chamber of Commerce (Inner Loop MRA)*, 55 St. Paul St.
Rochester, *Cohen, H. C., Company building—Andrews Building (Inner Loop MRA)*, 216 Andrews St.
Rochester, *Court Exchange Building—National Casket Company (Inner Loop MRA)*, 142 Exchange St.
Rochester, *Dewey, Chester, School No. 14 (Inner Loop MRA)*, 200 University Ave.
Rochester, *First National Bank of Rochester—Old Monroe County Savings Bank Building (Inner Loop MRA)*, 35 State St.
Rochester, *Gannett Building (Inner Loop MRA)*, 55 Exchange St.
Rochester, *Jewish Young Men's and Women's Association (Inner Loop MRA)*, 400 Andrews St.
Rochester, *Kirstein Building (Inner Loop MRA)*, 242 Andrews St.
Rochester, *Lehigh Valley Railroad Station (Inner Loop MRA)*, 99 Court St.
Rochester, *Little Theatre (Inner Loop MRA)*, 240 East Ave.
Rochester, *Michaels—Stern Building (Inner Loop MRA)*, 87 N. Clinton Ave.
Rochester, *Naval Armory—Convention Hall (Inner Loop MRA)*, 75 Woodbury Blvd.
Rochester, *Reynolds Arcade (Inner Loop MRA)*, 16 E. Main St.
Rochester, *Rundel Memorial Library (Inner Loop MRA)*, 115 South Ave.
Rochester, *Sibley Triangle Building (Inner Loop MRA)*, 20–30 East Ave.
Rochester, *University Club (Inner Loop MRA)*, 26 Broadway
Rochester, *Warner, H. H., Building (Inner Loop MRA)*, 72–82 St. Paul St.
Rochester, *Washington Street Rowhouses (Inner Loop MRA)*, 30–32 N. Washington St.
Rochester, *Watts, Ebenezer, House (Inner Loop MRA)*, 47 S. Fitzhugh St.
Rochester, *Wilder Building (Inner Loop MRA)*, 1 E. Main St.

Nassau County

Port Washington, *Sands—Willets Homestead*, 336 Port Washington Blvd.

New York County

New York, *Yiddish Art Theatre*, 189 Second Ave.

Oneida County

Vernon, *Vernon Center Green Historic District*, Roughly bounded by Park St.

Ulster County

Kingston, *Chestnut Street Historic District*, Roughly bounded by W. Chestnut St., Broadway, E. Chestnut, Livingston & Stuyvesant Sts.
Saugerties vicinity, *Trumpbour Homestead Farm*, 1789 Old Kings Hwy.

Wyoming County

Silver Lake, *Silver Lake Institute Historic District*, Roughly bounded by Wesley, Embury, Thompson, Haven, Lakeside & Lakeview Aves.

NORTH CAROLINA

Buncombe County

Asheville vicinity, *Church of the Redeemer*, 1202 Riverside Dr.
Leicester vicinity, *Camp Academy*, NC 63

Catawba County

Terrell, *Terrel Historic District*, NC 150 & SR 1848

Cumberland County

Carvers Creek vicinity, *Cool Springs*, Off SR 1607 at Cumberland

Martin County

Robersonville, *Little, W. J., House*, 109 N. Main St.

Nash County

Nashville, *Bissette—Cooley House*, W. First & E. Washington Sts.

Rockingham County

Eden, *King, Dr. Franklin, House—Idlewild*, 700 blk. of Bridge St.

Surry County

Mount Airy, *Mount Airy Historic District*, Main, Brown, Market, Franklin, W. Pine, Rockford, Worth, Cherry & Gilmer Sts. and Moore & Hines Aves.

Wake County

Wake Crossroads vicinity, *Rogers—Whitaker—Haywood House*, SR 2044 & US 401

Wilson County

Black Creek, *Aycock, Manalcus, House (Wilson MRA)*, Center St.
Black Creek, *Lucas, Dr. H. D., House (Wilson MRA)*, Center St.
Elm City vicinity, *Langley, W. H., House (Wilson MRA)*, N side of SR 1003
Elm City vicinity, *Webb-Barron—Wells House (Wilson MRA)*, E side SR 1512
Elm City, *Elm City Municipal Historic District (Wilson MRA)*, Roughly bounded by North, Pender, Branch, Wilson, Main and Anderson Sts.
Lucama, *Lucama Municipal Historic District (Wilson MRA)*, Roughly bounded by US 301, Railroad & Main Sts., Black Creek Rd. & Goldsboro St.
Sims vicinity, *Bullock—Dew House (Wilson MRA)*, NC 581
Stantonsburg vicinity, *Edmondson—Woodward House (Wilson MRA)*, NE cor. NC 58 & SR 1542
Stantonsburg, *Applewhite, W. H., House (Wilson MRA)*, Off NC 58
Stantonsburg, *Ward-Applewhite-Thompson House (Wilson MRA)*, S. side SR 1539
Wilson vicinity, *Barnes, General Joshua, House (Wilson MRA)*, W side of SR 1326 off jct of SR 1327

PENNSYLVANIA

Chester County

West Chester, *Sharples Homestead*, 22 Dean St.

Dauphin County

Middletown, *B'Nai Jacob Synagogue*, Nissley & Water Sts.

The 15-day commenting period for the following property is to be waived in order to assist the buildings preservation funding.

COLORADO

Denver County

Denver, *Littleton Creamery—Beatrice Foods Cold Storage Warehouse*, 1801 Wynkoop St.

[FR Doc. 85-20894 Filed 8-30-85; 8:45 am]

BILLING CODE 4310-70-M

## INTERSTATE COMMERCE COMMISSION

[Docket No. AB-6 (Sub-No. 264)]

### Burlington Northern Railroad Co.; Abandonment In Mercer and Dunn Counties, ND; Findings

The Commission has issued a certificate authorizing Burlington Northern Railroad Company to abandon its 40.86-mile rail line between Zap (milepost 80.50) and Killdeer (milepost 121.36) in Mercer and Dunn Counties, ND. The abandonment certificate will become effective 30 days after this publication unless the Commission also finds that: (1) A financially responsible person has offered financial assistance (through subsidy or purchase) to enable the rail service to be continued; and (2) it is likely that the assistance would fully compensate the railroad.

Any financial assistance offer must be filed with the Commission and the applicant no later than 10 days from publication of this Notice. The following notation shall be typed in bold face in the lower left-hand corner of the envelope containing the offer: "Rail Section, AB-OFA". Any offer previously made must be remade within this 10-day period.

Information and procedures regarding financial assistance for continued rail service are contained in 49 U.S.C. 10905 and 49 CFR Part 1152.

James H. Bayne,

*Secretary.*

[FR Doc. 8-20962 Filed 8-30-85; 8:45 am]

BILLING CODE 7035-01-M

## DEPARTMENT OF LABOR

### Mine Safety and Health Administration

[Docket No. M-85-81-C]

### Bartley and Bartley Coal Co.; Petition for Modification of Application of Mandatory Safety Standard

Bartley and Bartley Coal Co., P.O. Box 142, Rockhouse, Kentucky 41561 has filed a petition to modify the application of 30 CFR 75.1710 (cabs and canopies) to its No. 7 Mine (I.D. No. 15-02384) located in Pike County, Kentucky. The petition is filed under section 101(c) of the Federal Mine Safety and Health Act of 1977.

A summary of the petitioner's statements follows:

1. The petition concerns the requirement that cabs or canopies be installed on the mine's electric face equipment.

2. The No. 7 Mine is in the No. 1 Elkhorn seam ranging from 40 to 48 inches in height, with consistent ascending and descending grades creating dips in the coal bed.

3. Petitioner states that the use of a canopy on the mine's shuttle cars and roof bolting machines would result in a diminution of safety to the miners affected because the canopy would restrict the equipment operator's seating position and limit the operator's visibility.

4. For these reasons, petitioner requests a modification of the standard.

**Request for Comments**

Persons interested in this petition may furnish written comments. These comments must be filed with the Office of Standards, Regulations and Variances, Mine Safety and Health Administration, Room 627, 4015 Wilson Boulevard, Arlington, Virginia 22203. All comments must be postmarked or received in that office on or before October 3, 1985. Copies of the petition are available for inspection at that address.

Dated: August 23, 1985.

Patricia W. Silvey,

*Director, Office of Standards, Regulations and Variances.*

[FR Doc. 85-20864 Filed 8-30-85; 8:45 am]

BILLING CODE 4510-43-M

[Docket No. M-85-69-C]

### BethEnergy Mines Inc.; Petition for Modification of Application of Mandatory Safety Standard

BethEnergy Mines Inc., Room 1871—Martin Tower, Bethlehem, Pennsylvania 18016 has filed a petition to modify the application of 30 CFR 75.1404-1 (braking system) to its No. 58 Mine (I.D. No. 36-00957) located in Washington County, Pennsylvania. The petition is filed under section 101(c) of the Federal Mine Safety and Health Act of 1977.

A summary of the petitioner's statements follows:

1. The petition concerns the requirements that a trailing locomotive or equivalent device be used on trains that are operated on ascending grades.

2. Coal mined at the face is transported via shuttle car to section conveyor belts which transport the coal to a dumping point where it is dumped into mine cars. These cars are then hauled by mainline locomotives to a rotary dump where the coal is hoisted to the surface for processing. The empty mine cars are then brought back into the mine for reloading. On two sections, conveyors belts are not used and the shuttle cars dump the coal directly into the mine car.

3. Due to manpower distribution, little traffic, other than mainline locomotives, is on the haulage during production shifts. The track grades in the mine are basically level; however, these areas would be described as ascending grades.

4. As an alternate method, petitioner proposes that:

(a) In areas of the mines having ascending grades, a red light system will be employed. These lights will be located so that anyone waiting for a trip to travel an ascending grade will be in the clear;

(b) The red lights will be activated by a motorman when he arrives at the ascending grade;

(c) The red light will remain on until the last car has completely cleared the light;

(d) All access ways, if any, will also be connected to the red light system;

(e) No one will be allowed to enter the ascending grade areas while the trip is in this area;

(f) Signs will be posted and all employees will be instructed about this system and the procedures;

(g) If the red light system malfunctions, the dispatcher will be advised and will exercise special control over traffic in the ascending grade zones. Repairs will begin immediately to make the red light system operational; and

(h) If any other grades are encountered while the mine advances, this same proposed system will be incorporated.

5. Petitioner states that the proposed alternate method will provide the same

degree of safety for the miners affected as that afforded by the standard.

**Request for Comments**

Persons interested in this petition may furnish written comments. These comments must be filed with the Office of Standards, Regulations and Variances, Mine Safety and Health Administration, Room 627, 4015 Wilson Boulevard, Arlington, Virginia 22203. All comments must be postmarked or received in that office on or before October 3, 1985. Copies of the petition are available for inspection at that address.

Dated: August 23, 1985.

**Patricia W. Silvey,**

*Director, Office of Standards, Regulations and Variances.*

[FR Doc. 85-20865, Filed 8-30-85; 8:45 am]

BILLING CODE 4510-43-M

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**[Docket No. M-85-83-C]**

## Consolidated Coal Co.; Petition for Modification of Application of Mandatory Safety Standard

Consolidation Coal Company, Consol Plaza, Pittsburgh, Pennsylvania 15241 has filed a petition to modify the application of 30 CFR 75.305 (weekly examinations for hazardous conditions) to its Matthews Mine (I.D. No. 40-00520) located in Claibourne County, Tennessee. The petition is filed under section 101(c) of the Federal Mine Safety and Health Act of 1977.

A summary of the petitioner's statements follows:

1. The petition concerns the requirement that return air-courses be examined in their entity on a weekly basis.

2. The return entries were developed between 1968 and 1969 and roof conditions have deteriorated, rendering these air courses hazardous to travel and examine. Rehabilitation of the affected areas would expose miners to hazardous working conditions.

3. As an alternate method, petitioner proposes to establish three check points where certified persons can take air and gas measurements when making weekly examinations of the affected return air courses.

4. Petitioner states that the proposed alternate method will provide the same degree of safety for the miners affected as that afforded by the standard.

**Request for Comments**

Persons interested in this petition may furnish written comments. These comments must be filed with the Office of Standards, Regulations and Variances, Mine Safety and Health Administration, Room 627, 4015 Wilson Boulevard, Arlington, Virginia 22203. All comments must be postmarked or received in that office on or before October 3, 1985. Copies of the petition are available for inspection at that address.

Dated: August 23, 1985.

**Patricia W. Silvey,**

*Director, Office of Standards, Regulations and Variances.*

[FR Doc. 85-20866 Filed 8-30-85; 8:45 am]

BILLING CODE 4510-43-M

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**[Docket No. M-85-101-C]**

## Eastern Associated Coal Corp.; Petition for Modification of Applications of Mandatory Safety Standard

Eastern Associated Coal Corporation, One PPG Place, Pittsburgh, Pennsylvania 15222 has filed a petition to modify the application of 30 CFR 75.1105 (housing of underground transformer stations, battery-charging stations, substations, compressor stations, shops, and permanent pumps) to its Wharton No. 4 Mine (I.D. No. 46-01272) located in Boone County, West Virginia. The petition is filed under section 101(c) of the Federal Mine Safety and Health Act of 1977.

A summary of the petitioner's statements follows:

1. The petition concerns the requirement that air currents used to ventilate structures or areas enclosing electrical installations be coursed directly into the return.

2. All entries in the 1 South Mains are intake airways, and there are no return airways available to permit the 225 KVA AC transformer and the pump stations to be ventilated to the returns. The three pump stations are necessary to maintain the affected areas free of water.

3. As an alternate method to coursing the air currents which ventilate the electrical installations directly into the return, petitioner proposes to install dry chemical fire suppression devices on each of the installations.

4. Petitioner states that the proposed alternate method will provide the same degree of safety for the miners affected as that afforded by the standard.

**Request for Comments**

Persons interested in this petition may furnish written comments. These comments must be filed with the Office of Standards, Regulations and Variances, Mine Safety and Health Administration, Room 627, 4015 Wilson Boulevard, Arlington, Virginia 22203. All comments must be postmarked or received in that office on or before October 3, 1985. Copies of the petition are available for inspection at that address.

Dated: August 23, 1985.

**Patricia W. Silvey,**

*Director, Office of Standards, Regulations and Variances.*

[FR Doc. 85-20867 Filed 8-30-85; 8:45 am]

BILLING CODE 4510-13-M

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**[Docket No. M-85-11-M]**

## Franklin Consolidated Mines, Inc.; Petition for Modification of Application of Mandatory Safety Standard

Franklin Consolidated Mines, Inc., P.O. Box 508, Idaho Springs, Colorado 80452 has filed a petition to modify the application of 30 CFR 57.19003 (hoists) to its Franklin 73 Mine (I.D. No. 05-00630) located in Clear Creek County, Colorado. The petition is filed under section 101(c) of the Federal Mine Safety and Health Act of 1977.

A summary of the petitioner's statements follows:

1. The petition concerns the requirement that belt, rope, or chains not be used to connect driving mechanisms to personnel hoists.

2. The Freighter's Friend shaft is currently being rehabilitated. Upon completion, it will be the operating shaft for personnel, ore and materials. At that time, the Franklin 73 hoists will be used only for inspections, materials, maintenance and repairs.

3. As an alternate method, petitioner proposes to use a link-belt silent chain to drive the Nordberg, single drum, personnel-material hoist at the Franklin 73 shaft, until the Freighter's Friend shaft becomes operable.

4. For these reasons, petitioner requests a modification of the standard.

**Request for Comments**

Persons interested in this petition may furnish written comments. These comments must be filed with the Office of Standards, Regulations and Variances, Mine Safety and Health Administration, Room 627, 4015 Wilson Boulevard, Arlington, Virginia 22203. All comments must be postmarked or received in that office on or before October 3, 1985. Copies of the petition are available for inspection at that address.

Dated: August 23, 1985.

**Patricia W. Silvey,**

*Director, Office of Standards, Regulations and Variances.*

[FR Doc. 85-20868 Filed 8-30-85; 8:45 am]

BILLING CODE 4510-43-M

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**[Docket No. M-85-9-M**

## Hydrocarbon Resources Co; Petition for Modification of Application of Mandatory Safety Standard

Hydrocarbon Resources Company, Star Route 2, Box 192, Randlett Utah 84063 has filed a petition to modify the application of 30 CFR 57.19065 (hoisting procedures) to its Cottonwood Mine (I.D. No. 42-01789) located in Uintah County, Utah. The petition is filed under section 101(c) of the Federal Mine Safety and Health Act of 1977.

A summary of the petitioner's statements follows:

1. The petition concerns the requirement that conveyances not be lowered by the brakes alone except during emergencies.

2. Petitioner states that application of the standard would result in a diminution of safety to the miners affected because when the hoist is lowering miners and equipment under power, the motor is drawing down as if under load; the brakes and brake system become overheated more under this condition than if allowed to operate without power.

3. In lieu of lowering the conveyance under power and with brakes, as an alternate method, petitioner proposes to lower miners and equipment using only the brake causing less wear and stress on the conveyance.

4. For these reasons, petitioner requests a modification of the standard

### Request for Comments

Persons interested in this petition may furnish written comments. These comments must be filed with the Office of Standards, Regulations and Variances, Mine Safety and Health Administration, Room 627, 4015 Wilson Boulevard, Arlington, Virginia 22203. All comments must be postmarked or received in that office on or before October 3, 1985. Copies of the petition are available for inspection at that address.

Dated: August 23, 1985.

**Patricia W. Silvey,**

*Director, Office of Standards, Regulations and Variances.*

[FR Doc. 85-20869 Filed 8-30-85; 8:45 am]

BILLING CODE 4510-43-M

**[Docket No. M-85-47-C]**

## Jet Coal Company, Inc.; Petition for Modification of Application of Mandatory Safety Standard

Jet Coal Company, Inc., P.O. Box 276, Virgie, Kentucky 41572 has filed a petition to modify the application of 30 CFR 75.1710 (cabs and canopies) to its Maverick Mine (I.D. No. 15-07453) located in Pike County, Kentucky. The petition is filed under Section 101(c) of the Federal Mine Safety and Health Act of 1977.

A summary of the petitioner's statements follows:

1. The petition concerns the requirement that cabs or canopies be installed on the mine's electric face equipment.

2. The mine is in the No. 2 Elkhorn seam and ranges from 40 to 50 inches in height, with consistent ascending and descending grades creating dips in the coal bed.

3. Petitioner states that the canopies can strike and dislodge roof support, increasing the chances of an accident. The canopies also limit the equipment operator's visibility and restrict the operator's seating position, creating a potential hazard.

4. For these reasons, petitioner requests a modification of the standard.

### Request for Comments

Persons interested in this petition may furnish written comments. These comments must be filed with the Office of Standards, Regulations and Variances, Mine Safety and Health Administration, Room 627, 4015 Wilson Boulevard, Arlington, Virginia 22203. All comments must be postmarked or received in that office on or before October 3, 1985. Copies of the petition are available for inspection at that address.

Dated: August 23, 1985.

**Patricia W. Silvey,**

*Director, Office of Standards, Regulations and Variances.*

[FR Doc. 85-20870 Filed 8-30-85; 8:45 am]

BILLING CODE 4510-43-M

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**[Docket No. M-85-45-C]**

## Jim Walter Resources, Inc.; Petition for Modification of Application of Mandatory Safety Standard

Jim Walter Resources, Inc., P.O. Box C-79, Birmingham, Alabama 35283 has filed a petition to modify the application of 30 CFR 75.1002 (location of trolley wires, trolley feeder wires, high-voltage cables and transformers) to its No. 5 Mine (I.E. No. 01-01322) located in Tuscaloosa County, Alabama. The petition is filed under Section 101(c) of the Federal Mine Safety and Health Act of 1977.

A summary of the petitioner's statements follows:

1. The petition concerns the requirement that trolley wires and trolley feeder wires, high voltage cables, and transformers not be located inby the last open crosscut and be kept at least 150 feet from pillar workings.

2. Petitioner is planning to install a longwall mining unit in the No. 5 Mine. In order to safely and efficiently mine the coal seam, a 500 hp shearing machine, an approximately 1,000 hp face conveyor and a stage loader with a crusher unit will be used.

3. As an alternate method, petitioner proposes to use 2300 A.C. high voltage cables to supply power to permissible longwall face equipment in or inby the last open crosscut.

4. In support of this request, petitioner states that:

(a) The cables used will be a SHD-GC 5KV MSHA-approved jacketed cable. Each power conductor in this cable is completely surrounded by a grounded metal shield interconnected with MSHA-required ground fault protection;

(b) The cable will enter the permissible equipment through approved stuffing box lead entrances or approved couplers. The use of higher voltage motors results in lower current flows, thereby reducing the heating effect on the cable;

(c) A properly calibrated and maintained methane monitor will prevent energization of the cables when 2% or greater methane content is detected;

(d) The ground fault current will be limited to 6.25 amperes and a sensitive ground fault and lock out protection circuit will be provided to detect, trip and lockout any cable with a ground fault current of 90 milliamperes;

(e) With a 995 volt system, the possible short circuit fault current can exceed the rating of presently available circuit breakers. A 2300 volt system will provide a much safer condition in that interrupting devices of this voltage class are presently available with ratings at least equal to that required to interrupt the fault current flow; and

(f) The smaller current flow through the high voltage cable makes it less susceptible to damage from the repeated bending experienced in normal use, lessening the possibility of an arcing fault.

5. Petitioner states that the proposed alternate method will provide the same

degree of safety for the miners affected as that afforded by the standard.

**Request for Comments**

Persons interested in this petition may furnish written comments. These comments must be filed with the Office of Standards, Regulations and Variances, Mine Safety and Health Administration, Room 627, 4015 Wilson Boulevard, Arlington, Virginia 22203. All comments must be postmarked or received in that office on or before October 3, 1985. Copies of the petition are available for inspection at that address.

Dated: August 23, 1985.

**Patricia W. Silvey,**

*Director, Office of Standards, Regulations and Variances.*

[FR Doc. 85-20871 Filed 8-30-85; 8:45 am]

BILLING CODE 4510-43-M

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**[Docket No. M-85-91-C]**

## McLayne Resources, Inc.; Petition for Modification of Application of Mandatory Safety Standard

McLayne Resources, Inc., P.O. Box 393, Phelps, Kentucky 41553 has filed a petition to modify the application of 30 CFR 75.1710 (cabs and canopies) to its No. 1 Mine (I.D. No. 15-15175) located in Pike County, Kentucky. The petition is filed under section 101(c) of the Federal Mine Safety and Health Act of 1977.

A summary of the petitioner's statements follows:

1. The petition concerns the requirement that cabs or canopies be installed on the mine's electric face equipment.

2. The No. 1 Mine is in the No. 1 Warfield Seam ranging from 38 to 56 inches in height, with consistent ascending and descending grades creating dips in the coal bed.

3. Petitioner states that use of a canopy on the mine's equipment would result in a diminution of safety for the miners affected because the canopy will restrict the operator's seating position and limit the operator's visibility, as well as strike and dislodge roof supports, increasing the chances of an accident.

4. For these reasons, petitioner requests a modification of the standard.

**Request for Comments**

Persons interested in this petition may furnish written comments. These comments must be filed with the Office of Standards, Regulations and Variances, Mine Safety and Health Administration, Room 627, 4015 Wilson Boulevard, Arlington, Virginia 22203. All comments must be postmarked or received in that office on or before October 3, 1985. Copies of the petition are available for inspection at that address.

Dated: August 23, 1985.

**Patricia W. Silvey,**

*Director, Office of Standards, Regulations and Variances.*

[FR Doc. 85-20872 Filed 8-30-85; 8:45 am]

BILLING CODE 4510-43-M

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**[Docket No. M-85-82-C]**

## Oneida Coal Company, Inc.; Petition for Modification of Application of Mandatory Safety Standard

Oneida Coal Company, Inc., Rt. 2, Box 72, Sutton, West Virginia 26601 has filed a petition to modify the application of 30 CFR 75.503 (permissible electric face equipment; maintenance) to its Wolf Creek No. 1 Mine (I.D. No. 46-05243), Wolf Creek No. 3 Mine (I.D. No. 46-06043), Wolf Creek No. 4 Mine (I.D. No. 46-06213), Prestonia No. 11 Mine (I.D. No. 46-06557), Prestonia No. 12 Mine (I.D. No 46-06846) and Prestonia No. 14 Mine (I.D. No. 46-06445) all located in Braxton County, West Virginia and its Prestonia No. 15 Mine (I.D. No. 46-06522) located in Webster County, West Virginia. The petition is filed under section 101(c) of the Federal Mine Safety and Health Act of 1977.

A summary of the petitioner's statements follows:

1. The petition concerns the use of a locked padlock to secure battery plugs to machine-mounted battery receptacles on permissible, mobile, battery-powered machines.

2. As an alternate method, petitioner proposes to use metal locking devices, each consisting of a fabricated metal bracket and a thumb screw in lieu of padlocks to secure battery plugs to machine-mounted battery receptacles on permissible, mobile, battery-powered machines. The metal locking devices will be designed and used to prevent the threaded rings securing the battery plugs to the battery receptacles from unintentionally loosening. The metal locking devices will be securely attached to the battery receptacles to prevent accidental loss of the devices.

3. Petitioner states that the locking devices will be easier to maintain than padlocks because there are no keys to be lost and dirt cannot prevent the device from working as with a padlock.

4. Operators of permissible, mobile, battery-powered machines affected by this modification will be trained in the proper use of the locking device, trained in the hazards of breaking battery-plug connections under load, and trained in the hazards of breaking battery-plug connections in areas of the mine where electric equipment is required to be permissible.

5. For these reasons, petitioner requests a modification of the standard.

**Request for Comments**

Persons interested in this petition may furnish written comments. These comments must be filed with the Office of Standards, Regulations and Variances, Mine Safety and Health Administration, Room 627, 4015 Wilson Boulevard, Arlington, Virginia 22203. All comments must be postmarked or received in that office on or before October 3, 1985. Copies of the petition are available for inspection at that address.

Dated: August 23, 1985.

**Patricia W. Silvey,**

*Director, Office of Standards, Regulations and Variances.*

[FR Doc. 85-20873 Filed 8-30-85; 8:45 am]

BILLING CODE 4510-43-M

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**[Docket No. M-85-77-C]**

## Plateau Mining Co.; Petition for Modification of Application of Mandatory Safety Standard

Plateau Mining Company, P.O. Drawer PMC, Price, Utah 84501 has filed a petition to modify the application of 30 CFR 75.326 (aircourses and belt haulage entries) to its Star Point No. 2 Mine (I.D. No. 42-00171) located in Carbon County, Utah. The petition is filed under section 101(c) of the Federal Mine Safety and Health Act of 1977.

A summary of the petitioner's statements follows:

1. The petition concerns the requirement that intake and return air courses be separated from belt haulage entries.

2. As an alternate method, petitioner proposes to develop the coal mine with a two-entry longwall development system and use the belt entry as a separate intake split of air to the longwall face. The belt/intake entry will be provided with an environmental monitoring system for low-level carbon monoxide monitoring. This separate split of air will provide two separate intake air travel routes for the longwall panel.

3. Petitioner states that application of the standard would introduce increased roof fall potential, excessive chain pillar and longwall face loading, and rib roll hazards that could be avoided by two-entry longwall development panels

using the belt entry as a separate intake split of air to the longwall face.

4. Petitioner states that the proposed alternate method will provide the same degree of safety for the miners affected as that afforded by the standard.

**Request for Comments**

Persons interested in this petition may furnish written comments. These comments must be filed with the Office of Standards, Regulations and Variances, Mine Safety and Health Administration, Room 627, 4015 Wilson Boulevard, Arlington, Virginia 22203. All comments must be postmarked or received in that office on or before October 3, 1985. Copies of the petition are available for inspection at that address.

Dated: August 23, 1985.

**Patricia W. Silvey,**

*Director, Office of Standards, Regulations and Variances.*

[FR Doc. 85-20874 Filed 8-30-85; 8:45 am]

BILLING CODE 4510-43-M

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**[Docket No. M-85-53-C]**

## Shannon Coal Company, Inc.; Petition for Modification of Application of Mandatory Safety Standard

Shannon Coal Company, Inc., P.O. Box 576, McDowell, Kentucky 41647 has filed a petition to modify the application of 30 CFR 75.1710 (cabs or canopies) to its No. 1 Mine (I.D. No. 15-06287) located in Floyd County, Kentucky. The petition is filed under Section 101(c) of the Federal Mine Safety and Health Act of 1977.

A summary of the petitioner's statements follows:

1. The petition concerns the requirement that cabs or canopies be installed on the mine's electric face equipment.

2. Petitioner states that the use of canopies on its mining equipment would result in a diminution of safety for the miners affected because the canopy cuts or damages cables due to the height and uneven conditions of the bottom and roof, thus creating an electrical hazard to the operator. In addition, the canopies can strike and dislodge roof support, impair the operator's visibility, and create a cramped and uncomfortable seating position for the operator.

3. For these reasons, petitioner requests a modification of the standard.

**Request for Comments**

Persons interested in this petition may furnish written comments. These comments must be filed with the Office of Standards, Regulations and Variances, Mine Safety and Health Administration, Room 627, 4015 Wilson Boulevard, Arlington, Virginia 22203. All comments must be postmarked or received in that office on or before October 3, 1985. Copies of the petition are available for inspection at that address.

Dated: August 23, 1985.

**Patricia W. Silvey,**

*Director, Office of Standards, Regulations and Variances.*

[FR Doc. 85-20875 Filed 8-30-85; 8:45 am]

BILLING CODE 4510-43-M

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**[Docket No. M-85-97-C]**

## Tennessee Consolidated Coal Co.; Petition for Modification of Application of Mandatory Safety Standard

Tennessee Consolidated Coal Company, Box 878, Jasper, Tennessee 37347 has filed a petition to modify the application of 30 CFR 75.1303 (permissible blasting devices) to its No. 24 Mine (I.D. No. 40-00577), No. 28 Mine (I.D. No. 40-01586), No. 30 Mine (I.D. No. 40-01813), No. 34 Mine (I.D. No. 40-02830), No. 35 Mine (I.D. No. 40-02839), No. 39 Mine (I.D. No. 40-02804), No. 41 Mine (I.D. No. 40-02875), all located in Sequatchie County, Tennessee and its No. 32 Mine (I.D. No. 40-02666) located in Marion County, Tennessee. The petition is filed under section 101(c) of the Federal Mine Safety and Health Act of 1977.

A summary of the petitioner's statements follows:

1. The petition concerns the requirement that permissible blasting devices be used, that all explosives and blasting devices be used in a permissible manner, and that permissible explosives be fired only with permissible shot firing units.

2. As an alternative method, petitioner proposes to use the nonpermissible FEMCO Ten-Shot Blasting Unit. The unit will be used by an authorized person and will be used with well insulated blasting cable wires no smaller than No. 18 Brown and Sharp gauge.

3. The unit will be used with not more than:

a. Ten detonators with copper leg wires not over 30 feet long;

b. Ten detonators with iron leg wires 6 and 7 feet long;

c. Nine detonators with iron leg wires 8 and 9 feet long;

d. Eight detonators with iron leg wires 10 feet long;

e. Seven detonators with iron leg wires 12 feet long;

f. Six detonators with iron leg wires 14 feet long; and

g. Five detonators with iron leg wires 16 feet long.

4. In addition, the FEMCO Ten-Shot Blasting Unit will be used only:

a. With short-delay electric detonators with designated delay periods of 25 to 500 milliseconds;

b. If the lamp, which provides an indication of readiness, lights immediately upon insertion of the firing key and extinguishes immediately upon release of the key. This will be verified prior to connecting the unit to the blasting cable; and

c. With a battery pack having an open circuit voltage of at least 120 votes when installed. The pack will be replaced at intervals not to exceed 6 months.

5. Petitioner will attach the manufacturer's label specifying conditions of use for the unit and will install the manufacturer's sealing device on the housing of the unit.

6. Petitioner states that the proposed alternative method will provide the same degree of safety for the miners affected as that afforded by the standard.

**Request for Comments**

Persons interested in this petition may furnish written comments. These comments must be filed with the Office of Standards, Regulations and Variances, Mine Safety and Health Administration, Room 627, 4015 Wilson Boulevard, Arlington, Virginia 22203. All comments must be postmarked or received in that office on or before October 3, 1985. Copies of the petition are available for inspection at that address.

Dated: August 23, 1985.

**Patricia W. Silvey,**

*Director, Office of Standards, Regulations and Variances.*

[FR Doc. 85-20876 Filed 8-30-85; 8:45 am]

BILLING CODE 4510-43-M

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**[Docket No. M-85-46-C]**

## Vojo Coals Inc.; Petition for Modification of Application of Mandatory Safety Standard

Vojo Coals Inc., Route 1, Box 53, Pennington Cap, Viriginia 24277 has filed a petition to modify the application of 30 CFR 75.1710 (cabs and canopies) to its No. 3 Mine (I.D. No. 15-14101) located in Harlan County, Kentucky. the petition is filed under section 101(c) of the Federal Mine Safety and Health Act of 1977.

A summary of the petitioner's statements follows:

1. The petition concerns the requirement that cabs or canopies be installed on the mine's electric face equipment.

2. Petitioner states that the use of canopies on the affected equipment would cause damage to roof bolts and restrict the equipment operator's vision.

3. As an alternate method petitioner proposes to use treated wooden planks in combination with roof bolts and headers in lieu of cabs or canopies.

4. For these reasons, petitioner requests a modification of the standard.

**Request for Comments**

Persons interested in this petition may furnish written comments. These comments must be filed with the Office of Standards, Regulations and Variances, Mine Safety and Health Administration, Room 627, 4015 Wilson Boulevard, Arlington, Virginia 22203. All comments must be postmarked or received in that office on or before October 3, 1985. Copies of the petition are available for inspection at that address.

Dated: August 23, 1985.

**Patricia W. Silvey,**

*Director, Office of Standards, Regulations and Variances.*

[FR Doc. 85-20877 Filed 8-30-85; 8:45 am]

BILLING CODE 4510-43-M

## Office of Pension and Welfare Benefit Programs

**[Application No. D-5053 et al.]**

## Proposed Exemptions; First Nat'l Bank of Chicago, et al.

**AGENCY:** Pension and Welfare Benefit Programs, Labor.

**ACTION:** Notice of Proposed Exemptions.

**SUMMARY:** This document contains notices of pendency before the Department of Labor (the Department) of proposed exemptions from certain of the prohibited transaction restrictions of the Employee Retirement Income Security Act of 1974 (the Act) and/or the Internal Revenue Code of 1954 (the Code).

**Written Comments and Hearing Requests**

All interested persons are invited to submit written comments or requests for a hearing on the pending exemptions, unless otherwise stated in the Notice of Pendency, within 45 days from the date of publication of this **Federal Register** Notice. Comments and requests for a hearing should state the reasons for the writer's interest in the pending exemption.

**ADDRESS:** All written comments and requests for a hearing (at least three copies) should be sent to the Office of Fiduciary Standards, Pension and Welfare Benefit Programs, Room C-4526, U.S. Department of Labor, 200 Constitution Avenue, NW., Washington, D.C. 20216. Attention: Application No. stated in each Notice of Pendency. The applications for exemption and the comments received will be available for public inspection in the Public Documents Room of Pension and Welfare Benefit Programs, U.S. Department of Labor, Room N-4677, 200 Constitution Avenue, NW., Washington, D.C. 20216.

**Notice of Interested Persons**

Notice of the proposed exemptions will be provided to all interested persons in the manner agreed upon by the applicant and the Department within 15 days of the date of publication in the **Federal Register.** Such notice shall include a copy of the notice of pendency of the exemption as published in the **Federal Register** and shall inform interested persons of their right to comment and to request a hearing (where appropriate).

**SUPPLEMENTARY INFORMATION:** The proposed exemptions were requested in applications filed pursuant to section 408(a) of the Act and/or section 4975(c)(2) of the Code, and in accordance with procedures set forth in ERISA Procedure 75-1 (40 FR 18471, April 28, 1975). Effective December 31, 1978, section 102 of Reorganization Plan No. 4 of 1978 (43 FR 47713, October 17, 1978) transferred the authority of the Secretary of the Treasury to issue exemptions of the type requested to the Secretary of Labor. Therefore, these notices of pendency are issued solely by the Department.

The applications contain representations with regard to the proposed exemptions which are summarized below. Interested persons are referred to the applications on file with the Department for a complete statement of the facts and representations.

**First National Bank of Chicago Pension Trust (the Plan) Located in Chicago, Illinois**

[Application No. D-5053]

*Proposed Exemption*

The Department is considering granting an exemption under the authority of section 408(a) of the Act and section 4975(c)(2) of the Code and in accordance with the procedures set forth in ERISA Procedure 75-1 (40 FR 18471, April 28, 1975). If the exemption is granted the restrictions of section 406(a), 406(b)(1) and 406(b)2) of the Act and the sanctions resulting from the application of section 4975 of the Code, by reason of section 4975(c)(21) (A) through (E) of the Code shall not apply to: (1) The proposed purchase by the Plan of certain real property (the Property) from First Chicago Building Corporation (the Building Corp.), a party in interest with respect to the Plan; (2) the lease (the Lease) of the Property by the Plan to the Building Corp., provided that the terms and conditions of the subject transactions are at least as favorable to the Plan as those which the Plan could receive in similar transactions with an unrelated party; and (3) the sublease of space in the Property by the Building Corp. to the First National Bank of Chicago (the Bank), the Plan sponsor, provided that the terms of the sublease are at arm's-length and that no profit enures to the Building Corp. as a result of the sublease.

*Summary of Facts and Representations*

1. The Plan is a defined benefit plan which as of December 1, 1982 had 9,495 participants. As of January 1, 1983, the Plan had assets of $389,171,128. The Bank is the sponsor and trustee of the Plan. The Building Corp. is a wholly owned subsidiary of the Bank.

2. The applicant is seeking an exemption which will permit the plan to buy the Property from the Building Corp. and then lease the Property back to the Building Corp. The Property, which is located in Chicago's downtown business district, has a land area of approximately 8,600 square feet and includes a five-story office building built in 1912. The applicant represents that the most attractive aspect of the proposed transactions to the Plan is the potential for assemblage of the Property with an adjacent site (the Bell Federal Site) currently owned by the Plan and subsequent redevelopment of the combined parcels.

3. The Bell Federal Site is encumbered by a ground lease (the Bell Federal Lease) held by Bell Federal Savings and Loan (Bell Federal) which was entered into by the Plan in 1953 and continues to the year 2103. The Bell Federal Site consists of approximately 17,195 square feet and is improved with a thirteen-story office building constructed 1895-1914. The applicant represents that the assemblage by the Plan of the Property with the Bell Federal Site would significantly increase the redevelopment potential of the Bell Federal Site, in that, the value of the two parcels assembled would exceed the sum of their values standing alone. The Bell Federal site is

zoned for a floor area ratio (FAR) of 16.0 and is only marginally adequate in its land area to justify new office development. The FAR that would be allowed in a new high-rise office building on the assembled two parcels would probably approach 28.0, which the applicant represents is more than sufficient to warrant redevelopment. The increase in FAR results in substantially more rentable space than could be built on the two parcels standing alone. With an FAR of 16.0, the rentable space of the two individual parcels would total 412,700 square feet [(16×8600)+(16×17,195)=412,700]. With an FAR of 28.0, the rentable space for the combined parcel would be 722,000 square feet [28×(8600+17,195)= 722,000]. In addition, the applicant represents that the combined value and redevelopment potential of the two parcels would put the Plan in a better position to negotiate an early termination of the Bell Federal Lease which, as noted above, extends to the year 2103. In addition, the applicants represent that the changing nature of the thrift industry may also affect Bell Federal's occupancy requirements and/or capital needs in a manner that predisposes Bell Federal to negotiate early termination. This combination of factors has led the Bank to estimate that the Bell Federal Lease interest could be terminated and the redevelopment possibilities pursued within the next ten years.

4. The proposed purchase price for the Property is $3,350,000, which is 95% of fair market value of the Property. Real Estate Analysis Corporation, an independent real estate appraising firm located in Chicago, Illinois, represents that as of August 1, 1983 the fair market value of the Property was $3,500,000. This figure represents less than 1% of the value of the Plan's assets. The appraisal price was for the Property "as is" as of August 1, 1983 and as such does not reflect the approximately $1,150,000 in improvements required to be made by the Building Corporation under the Lease. In addition, the appraisal does not consider the assemblage value of the Property with the Bell Federal Site, which the applicant represents would significantly increase the potential value of the Property to the Plan.

5. The Lease will be a 20 year triple net lease, under which the Plan retains virtually none of the costs of ownership: The Building Corp. will be responsible for operating expenses, repairs, replacements and maintenance (structural and non-structural), insurance, real estate taxes and special assessments. The Building corp. has made renovations which include, among other things: All interior partitions and flooring and ceiling materials on the second through fifth floors have been replaced; a completely new roof has been put on the entire building; new electrical service and electrical panels have been installed on each floor; new air-conditioning units have been installed on each floor; and a new electric heating system has been installed throughout the building. The cost to the Building Corp. of these improvements was approximately $1,150,000, as mentioned in paragraph 4, above.

6. The Building Corp. will pay the Plan an annual rent of $384,000 in the first Lease year on a triple net basis. The Lease contains an escalation clause that results in an increase in net rent by 30% of the Consumer Price Index annually over the Lease term. Callan Associates, Inc. (Callan), an independent investment consulting firm, has been retained to act as independent Plan fiduciary with respect to the proposed transactions. Callan represents that it is independent of the Bank and the Building Corp. and that it is familiar with and accepts its duties, responsibilities and obligations as a fiduciary under the Act. Callan has estimated that the total value of the expenses the Building Corp. will incur under the Lease, including the rent, would equate to a gross annual rent of $834,033. Callan represents that this rental rate is at least at market rate, and that the escalation clause is also at market rate.

7. The Building Corp. will be permitted under the Lease to sublet all or any portion of the Property with the consent of the Plan, but will remain primarily liable for payment of all of the rent and lessee's other obligations. It is anticipated that the Building Corp. will initially have two subtenants. Walgreen Co. will sublet the first floor and mezzanine pursuant to a lease between the Building Corp. and Walgreen Co. entered March 30, 1983 (the Walgreen's Lease) and extending for a term of twenty years, subject to lessor's right to cancel any time after the fifth lease year, as described below. Walgreen Co. will pay an annual rent of $259,000 for the first fifteen years and $280,000 for the final five years of its Lease. The Bank will sublet the second thru fifth floors and the basement. The Bank will pay an annual rent of $508,962.60 to the Building Corp. for the first year of its sublease. The Bank will pay 75% of any increase in operating expenses, taxes and rentals payable by the Building Corp. The Building Corp. will therefore receive a total of $767,962.60 in rents under the first year of the subleases. The applicant represents that this amount includes no profit for the Building Corp. nor will it for the term of the Lease. The subleases will not affect the Building Corp.'s liability for payment of the rent or the amount of the rent under the Lease.

8. The Lease between the Plan and the Building Corp. and the Walgreen's Lease both provide for termination by the lessor at any time after the fifth year of the Walgreen's Lease in the event the Plan intends to demolish the existing improvements on the Property. The applicant represents that the demolition provisions were structured to maximize the redevelopment potential of the Property. However, the Plan may incur costs if it elects to terminate the Lease. The cost of the Plan's election to terminate the Lease is a payment to Walgreen Co. for the unamortized value of leasehold improvements paid for by Walgreen Co. (These improvements, totalling approximately $300,000, are amortized evenly over a 12½ year period.) Since the Lease cannot be terminated prior to its sixth year, the maximum cost to the Plan for electing to terminate the Lease is $180,000. After 12½ years, the Plan can terminate the Lease with no payment due to Walgreen Co.

9. The applicant represents that the ability to terminate the Lease for redevelopment opportunities was essential to the Plan in negotiating the Lease provisions with the Building Corp. It was also considered necessary to have a sufficiently long lease period to provide security for the Plan if redevelopment is not a viable option in the short term. The cost to the Plan and exact timing of a termination of the Bell Federal Lease are not predictable with certainty. The applicant represents that the market conditions (supply-demand balance) for new office space in Chicago's central business district do not appear as favorable at present as they may be later in the decade of the 1980's, by which time there should have been an absorption of the substantial amount of vacant space in the new generation of office buildings now leasing or nearing completion. The applicant represents that because of the uncertainties surrounding redevelopment potential, it was viewed as prudent to provide an assured income stream for a time period substantially longer than the expected horizon for redevelopment. These considerations resulted in the Plan's proposal to make, as lessor, a 20-year absolute net lease with the Building Corp. for the entirety of the Property.

10. Callan surveyed rental rates for comparable office space in downtown Chicago and talked with commercial real estate brokers and represents that the rent to be paid by the Building Corp. is in excess of market rates given that the Lease is triple net. This provides an 11½% rate of return to the Plan on its investment in the first lease year.

11. After reviewing the investment merits of the Property, the goals and objectives of the Plan, the overall asset policy of the Plan, and the entire portfolio of the Plan and acting as an independent fiduciary of the Plan, Callan represents:

(1) The terms of the sales contract and Lease agreements for the proposed purchase are very beneficial to and protective of the rights of the participants of the Plan;

(2) The terms of the sales contract and Lease agreements for the proposed purchase are at least as beneficial to the Plan as an arms-length transaction with an unrelated party, in particular, the rent is not less than what the Plan could receive in the market place from unrelated parties;

(3) The sublease from the Building Corp. to the Bank will not result in any profit to the Building Corp. or the Bank;

(4) The goals and objectives of the Plan are compatible with and allow for the purchase of real estate and more specifically the Property;

(5) The purchase of the Property would add additional diversification to the real estate presently held by the Plan. This additional diversification would be both by type of property held, as well as geographic location; and

(6) The investment merits of the Property when judged without respect to redevelopment potential are at least equal to other real properties held by the Plan.

12. Callan will have the responsibility of monitoring the terms and conditions of the Lease on behalf of the Plan to ensure that the Plan's rights are enforced.

13. In summary, the applicant represents that the proposed transactions will satisfy the requirements of section 408(a) of the Act as follows: (1) The trustee of the Plan represents that the proposed transactions will be in the best interests of the participants and beneficiaries of the Plan; (2) the transactions have been approved by Callan, an independent fiduciary of the Plan; (3) the sales price of the Property was determined by an independent appraiser; (4) an independent fiduciary will monitor and enforce the terms and conditions of the Lease on behalf of the Plan; (5) the Plan will receive at least fair market rent for the Property; and (6) the Plan's acquisition of the Property will enhance the value of the Property as well as that of an adjacent parcel owned by the Plan.

For Further Information Contact: David Lurie of the Department, telephone (202) 523-8884. (This is not a toll-free number.)

**The Medical Clinic, P.A. Profit Sharing Plan (the Profit Sharing Plan) The Medical Clinic, P.A. Money Purchase Pension Plan (the Pension Plan) (together, the Plans) Located in Jackson, Mississippi**

[Application Nos. D-5903 and D-5904]

*Proposed Exemption*

The Department is considering granting an exemption under the authority of section 408(a) of the Act and section 4975(c)(2) of the Code and in accordance with the procedures set forth in ERISA Procedure 75-1 (40 FR 18471, April 28, 1975). If the exemption is granted the restrictions of section 406(a) and 406 (b)(1) and (b)(2) of the Act and the sanctions resulting from the applications of section 4975 of the Code, by reason of section 4975(c)(1) (A) through (E) of the Code shall not apply to (1) the sale of certain real property (the Land) to the Plans by Manship Rentals, a party in interest with respect to the Plans, provided by the Plans pay no more than the fair market value of the Land on the date of the sale; (2) the lease of the Land by the Plans to The Medical Clinic, P.A., the sponsor of the Plans, under the terms described in this notice of proposed exemption, provided such terms are not less favorable to the Plans than those obtainable in an arm's-length transaction with unrelated parties; and (3) the assumption by the Plans of a portion of an outstanding note between Manship Rentals and First National Bank, the trustee of the Plans.

*Summary of Facts and Representations*

1. The Profit Sharing Plan is a defined contribution plan with approximately thirty-five participants and assets of approximately $550,009 as of January 14, 1985. The Pension Plan is a money purchase pension plan with approximately thirty-five participants and assets of approximately $428,326 as of January 14, 1985. First National Bank of Jackson, Mississippi is the Trustee for both Plans and it makes investment decisions for the Plans. The Medical Clinic, P.A. (the Employer) is a Mississippi professional services corporation specializing in internal medicine. Its principal place of business is located at 746 Manship Street, Jackson, Mississippi. As of September 30, 1984, the Employer had assets of approximately $200,575. Manship Rentals is a Mississippi partnership (the Partnership) comprised of shareholders and officers of the Employer. Its primary business consists of leasing real property to the Employer, and it had assets with a fair market value of approximately $1,091,960 as of December 31, 1984.

2. The Employer requests an exemption to permit the Plans to purchase the Land from the Partnership, which the Plans would subsequently lease to the Employer. The Land is approximately 51,688 square feet located at 746 Manship Street and 735 Popular Boulevard, Mississippi, where the Employer has its principal place of business. The Land is improved by a clinic facility which is also owned by the Partnership and leased to the Employer; however, ownership of the clinic facility will be retained by the Partnership until the expiration of the proposed lease (the Lease) discussed below. According to an appraisal performed by Randal Craft of Randal Craft Realty Co., Inc., Jackson, Mississippi, on August 18, 1983 and updated on September 12, 1984, the Land has a fair market value of $258,438. Mr. Craft represents that he is unrelated to the Employer and the Partnership.

3. The Plans will purchase the Land for the total purchase price of $258,000 or the fair market value at the time of sale, whichever is less. The Pension Plan will pay $32,602 in cash and assume a $72,541 obligation on an outstanding note (the Note) between the Partnership and First National Bank of Jackson, Mississippi (the Bank), the Trustee of the Plans. The Profit Sharing Plan will pay $47,398 in cash and assume a $105,459 obligation under the Note. Acquisition of the Land by the Plans will result in each Plan having less than 25% of its assets invested in the Land.

The Note is payable in total monthly installments of $11,060, including interest at 9.75%, and the final installment is due on February 1, 1998. Of that amount, the Profit Sharing Plan will pay $811 per month. The total outstanding balance on the Note was approximately $963,345 on June 30, 1985. The Plans will pay no closing costs or fees with regard to their assumption of a portion of the Note. The Bank has agreed that, in the event of default by the Partnership on its obligations under the Note, it will not foreclose on the Land. The Bank has accepted as substitute collateral on the Note the Employer's rights and obligations under the twenty-five year Lease, under which it would be bound to pay to the Plans

the fair market rental value of the Land. At the expiration of the twenty-five year period covered by the Lease, the Plans would receive clear title to the Land and the improvements thereon.

4. The Lease will be for a term of twenty-five (25) years. The minimum monthly rental under the Lease, which will be the monthly rental rate for the first year, will be $3,325, which amount was determined by Mr. Craft to be the fair market rental value. The monthly rental rate will be reviewed and updated annually, but it will never be lower than the minimum monthly rental. The Employer will pay all ad valorem taxes assessed against the Land during the term of the Lease and will maintain liability insurance on the Land to enable the Employer to hold the Plans harmless from any liability for any damages or injuries occurring to third parties on the Land. At the expiration of the twenty-five year term of the Lease, title to the improvements on the Land will be transferred to the Plans.

5. The Employer has retained Great Southern National Bank of Jackson, Mississippi to act as the independent fiduciary (the Independent Fiduciary) for the Plans. The Independent Fiduciary represents that it is unrelated to the Employer and the Partnership. The Independent Fiduciary will be responsible for approving the final terms of the Lease and monitoring the completion of the transactions. It will also review and update the monthly rental rate under the Lease annually, for which it will use independent appraisers to determine the fair market rental value. The Independent Fiduciary will verify the timely payment of rent under the Lease and will take whatever actions are necessary to enforce the rights of the Plans in the transactions.

6. The Independent Fiduciary represents that it has examined the proposed purchase of the Land by the Plans and the terms of the proposed Lease. It represents that the terms of the transactions are in the best interests of the Plans and their participants and beneficiaries, that the proposed rate of return under the Lease is very good, and that the Lease provides the Plans with terms at least as favorable as they would receive from an independent third party. The Independent Fiduciary further represents that it has reviewed the Plans' portfolios and has examined the impact that the proposed transactions will have on the diversity of assets in the Plans and on the Plans' liquidity requirements, and recommends after such review that the Plans enter into the purchase and lease of the Land.

7. In summary, the applicant represents that the proposed transactions meet the statutory criteria of section 408(a) of the Act because:

(a) The Plans will pay no more than fair market value for the Land, and will receive fair market rental value for the Land, as determined by an independent appraiser;

(b) The Lease will be monitored by an independent fiduciary; and

(c) The Independent Fiduciary has determined that the proposed transactions are in the interests of and protective of the Plans and their participants and beneficiaries.

For Further Information Contact: Ms. Linda Shore of the Department, telephone (202) 523-8196. (This is not a toll-free number.)

**Rosen's Furniture Company, Inc., Profit Sharing Plan (the Plan), Located in East Stroudsburg, Pennsylvania**

[Application No. D-5911]

*Proposed Exemption*

The Department is considering granting an exemption under the authority of section 408(a) of the Act and section 4975(c)(2) of the Code and in accordance with the procedures set forth in ERISA Procedure 75-1 (40 FR 18471, April 28, 1975). If the exemption is granted the restrictions of section 406(a) and 406(b) (1) and (2) of the Act and the sanctions resulting from the application of section 4975 of the Code, by reason of section 4975(c)(1)(A) through (E) of the Code shall not apply to the sale of certain real property by the Plan to Rosen's Enterprises Limited (the Partnership), a party in interest with respect to the Plan, provided the terms of the sale are as favorable to the Plan as those obtainable in an arm's-length transaction with an unrelated party on the date of the consummation of the transaction.

*Summary of Facts and Representations*

1. The Plan is a profit sharing plan with 25 participants. The independent trustee of the Plan is the Hazelton Bank (the Trustee). The Plan had total assets of $1,404,815 as of May 31, 1984. Rosen's Furniture Company, Inc. (the Employer) is a small, closely held corporation engaged in the business of selling furniture to a retail market.

2. On May 20, 1963, the Employer established a profit sharing plan and in 1966, it sold a warehouse located in Monroe County, Pennsylvania (the Warehouse) to the Plan for the amount of $12,500. The Employer then entered into a lease agreement (the Old Lease) with the Plan whereby the Employer leased the Property for use as a warehouse. This lease arrangement continued until April of 1974 when the Warehouse was condemned by the Redevelopment Authority of Monroe County. The condemnation resulted in the Plan's receiving $35,000 in condemnation proceeds. During 1974, the Plan constructed a new warehouse (the New Warehouse) at a cost of $183,850. The New Warehouse is presently owned by the Plan and occupied by the Employer pursuant to a lease arrangement (the New Lease) which provides net rental to the Plan of $2,200 per month.[1]

3. The Trustee seeks an exemption to permit the Plan to sell the New Warehouse to the Partnership. The partners of the Partnership are Messrs. Albert, David and Herbert Rosen (the Rosens). The Rosens each own a one-third capital and profits interests in the Partnership and they constitute the majority shareholders of the Employer. The proposed sales price is $275,000 in cash.

4. Due to growth in its business, the Employer seeks additional warehouse space to accommodate its increasing business demands. The applicant represents that under the New Lease, the construction of the necessary additions to the New Warehouse would create administrative burdens. After the consummation of the sale, the Partnership will then lease the New Warehouse to the Employer.

5. An independent appraisal (the Appraisal) of the property was performed by Ray Roberts, ASA, CA-S, a broker and real estate appraiser (the Appraiser) located in East Stroudsburg, Pennsylvania. The Appraiser established the fair market value of the New Warehouse at $225,000. The Appraiser used the following approaches to determine fair market value:

(1) Cost approach = $275,000.

(2) Income approach = $195,000.

(3) Sales comparison approach = $259,000.

The Appraiser stated that in his opinion the income and sales comparison approaches more closely reflect the typical buyer's analysis as evidenced in the market place. The Appraiser established the fair market value, based upon the above-described methods of valuation, at $225,000 as of September 4, 1984. The Partnership proposes to purchase the New

[1] The Department granted an administrative exemption, PTE 83-35 (48 FR 10951), which exempted the Lease from March 1983 through March 1988. IN PTE 83-85, the Department noted that it expressed no opinion as to the applicability of section 414 of the Act to the Old Lease. The Department again notes that it expresses no opinion with respect to this issue.

Warehouse for $275,000. This proposed purchase price is based upon the cost approach to valuation set forth in the Appraisal. The applicant represents that this purchase price affords the Plan the highest price it could reasonably obtain for the sale or the New Warehouse.

6. The Trustee is an independent trustee which is unrelated to the Employer. It has represented that it has reviewed the proposed sale of the New Warehouse. The Trustee represents that the proposed sales price of $275,000 is the highest price that the Plan could expect from the sale of the New Warehouse to an unrelated party and represents at least fair market value. This conclusion is based upon the Trustee's review of the Appraisal. The Trustee has ascertained that the Appraiser is independent and qualified to make an appraisal of the New Warehouse, and has knowledge of the New Warehouse because he has performed prior appraisal on the New Warehouse.

7. The Trustee has determined that the Plan should sell the New Warehouse at this time. It has considered whether the Plan should continue to hold the New Warehouse until the New Lease expires in March of 1988, in anticipation of realizing greater benefits from its appreciation in value. The Trustee concluded that the New Warehouse is located in an area which is not subject to increasing demand for real estate. There are no factors, such as planned business expansion in the area, which would indicate that demand for real estate in the area will increase appreciably in the future. The Trustee states that the proposed sale of the New Warehouse would permit immediate realization of cash which could be invested for the benefit of the Plan, rather than the risk associated with continuing to hold the New Warehouse in anticipation of uncertain appreciation to be realized at a future date.

8. The Trustee represents that the current income-producing potential of the New Warehouse is fixed by the terms of the New Lease until March of 1988. The Trustee believes that the Plan can earn more income from investing the proceeds from the sale of the New Warehouse than can now be obtained from the rents under the New Lease. The Trustee notes that there are several alternative investments available to the Plan with respect to the proceeds of the sale. Based upon its review of the performance of such alternative investments, the Trustee has determined that it could reasonably anticipate that the $275,000 proceeds from the sale could be invested at a rate which would yield approximately $30,250 in annual income. When compared to the current return of $26,400 on the New Warehouse under the terms of the New Lease, it is anticipated that the Plan could earn approximately $3,850 more per year from investment of the sale proceeds than can be earned from rentals under the New Lease. Thus, in addition to realizing a profit of $91,150 profit from the sale of the New Warehouse (the difference between the proposed sales price of $275,000 and the cost to the Plan of $183,850 for the New Warehouse), the Plan could derive an economic benefit from such additional investment income.

9. In summary, the applicant represents that the proposed transaction meets the statutory criteria of section 408(a) of the Act because:

(1) This will be a one-time cash transaction;

(2) The Plan will be receiving at least fair market value for its asset; and

(3) The Plan's independent trustee has determined that the proposed transaction is in the interests of and protective of the Plan and its participants and beneficiaries.

*Tax Consequences of Transaction*

The Department of the Treasury has determined that if a transaction between a qualified employee benefit plan and its sponsoring employer (or affiliate thereof) results in the plan either paying less than or receiving more than fair market value such excess may be considered to be a contribution by the sponsoring employer to the plan and therefore must be examined under applicable provisions of the Internal Revenue Code, including sections 401(a), 404 and 415.

*For Further Information Contact:* Ms. Linda Hamilton of the Department, telephone (202) 523-8881. (This is not a toll-free number.)

**WLB Group, Inc. Profit Sharing Plan and Trust (the Plan) Located in Tucson, Arizona**

[Application No. D-6020]

*Proposed Exemption*

The Department is considering granting an exemption under the authority of section 408(a) of the Act and section 4975(c)(2) of the Code and in accordance with the procedures set forth in ERISA Procedure 75-1 (40 FR 18471, April 28, 1975). If the exemption is granted the restrictions of section 406(a), 406(b)(1) and (b)(2) of the Act and sanctions resulting from the application of section 4975 of the Code, by reason of section 4975(c)(1) (A) through (E) of the Code shall not apply to the proposed cash sale by the Plan of certain real property and certain personal property located therein (together, the Property) to the WLB Group, Inc. (the Employer), the sponsor of the Plan, provided that all terms of such sale are at least as favorable to the Plan as those which the plan could obtain in an arm's-length transaction with an unrelated party.

*Summary of Facts and Representations*

1. The Plan is a defined contribution pension plan with 30 participants and total assets of $387,850.38 as of January 31, 1985. The Employer is a closely-held Arizona corporation engaged in consulting services related to civil engineering, land planning, landscape architecture and land surveying in Tucson and Phoenix, Arizona. The trustees of the Plan are William C. Walker, E. Fred Lowrey and David P. Valentine (the Trustees), each of whom is an officer of the Employer.

2. Among the assets of the Plan is the Property, a residential resort condominium unit in Maui, Hawaii. The Plan purchased the Property from unrelated parties in 1983 for a purchase price of $140,000, paying $28,000 in cash and becoming obligated under a mortgage for the remaining $112,000. The Trustees represent that this purchase price represented a bargain price for the Property, as the Plan purchased it from individuals who were in divorce proceedings and needed immediate cash to reach agreed property settlements. As of April 24, 1985, the Property had an appraised fair market value of $169,000, according to Edwin Higashiguchi, MAI (Higashiguchi), a professional real estate appraiser in Maui, Hawaii. The Trustees represent that the Plan's projected income from rentals on the Property was expected to meet or exceed the Plan's mortgage payments while the Property appreciated as a long-term investment for the Plan. The Trustees represent that the Property has not been leased to any parties in interest with respect to the Plan. However, rental market conditions have not met expectations and the Plan is losing money on the Property. In order to alleviate this negative cash flow, the Employer proposes to purchase the Property from the Plan and the Trustees are requesting an exemption to permit this transaction.

3. The Trustees have appointed Daniel H. O'Connell, Esq. (O'Connell) to act as an independent fiduciary on behalf of the Plan to determine whether the proposed transaction is in the best interests of the Plan and to represent the Plan in the consummation of the transaction if the requested exemption is granted. O'Connell is a tax attorney in the law firm of O'Connell and

Associates of Tucson, Arizona who represents that he is sufficiently familiar with the fiduciary responsibilities imposed by the Act to act in this capacity and that he is independent of and unrelated to the Employer. It is proposed that the Employer will pay the Plan cash in the amount of the full appraised fair market value of the Property as of the date of such sale and will pay all expenses related to the proposed sale transaction. In addition, the Employer will pay the Plan for certain moveable furnishings (the Furniture) which are located in the Property. The cost of the Furniture was included in the Property's purchase price when the Plan bought the Property in 1983. O'Connell represents that the Furniture was not included in Higashiguchi's appraisal because Higashiguchi was not informed that the Furniture would be included in a contemplated sale of the Property. However, O'Connell represents that the Furniture has a fair market value of $3,500, based on an oral appraisal rendered by Higashiguchi after an inspection of the Property. Thus, the proposed projected purchase price of the Property, including the Furniture, will be $172,500, but Higashiguchi's appraisal will be updated as of the date of the proposed sale to reflect any increase in the Property's fair market value since Higashiguchi's appraisal of April 27, 1985. Upon receipt of the cash purchase price from the Employer, the Plan will immediately pay off the outstanding mortgage of $112,000, leaving $60,500 (based on a purchase price of $172,500) in cash proceeds to the Plan. Total net rental proceeds received by the Plan from the Property to date amount to $5,929.00, leaving the Plan with total receipts from the Property, after its proposed sale to the Employer, of $66,429.00. The Plan's cash expenditures on the Property to date, including down payment, taxes, principal and interest payments on the mortgage, utilities and condominium fees, total $63,228.64.

4. O'Connell represents that he has reviewed all surrounding circumstances and terms of the proposed transaction and has determined that the Plan's sale of the Property to the Employer, as proposed, will be in the Plan's best interests. O'Connell has verified that the Plan's expenses relating to the Property are exceeding rental income from the Property. He has determined that if this situation persists, the Property's negative cash flow will consume all of the Plan's liquid assets in 1986, requiring a forced sale of the Plan's marketable securities to maintain sufficient liquidity under market conditions which cannot be predicted. The Plan's sale of the Property will terminate this negative cash flow, to which O'Connell sees no foreseeable end under foreseeable market conditions. Additionally, O'Connell notes that the Property currently constitutes approximately 38 percent of the Plan's total assets and that a sale of the Property will enable the Plan to achieve better diversification. O'Connell's investigation to the real estate market conditions in the vicinity of the Property reveals that the Property is located in a "flat" market with little or no likelihood of appreciation over the next few years. O'Connell states that the Property's appreciation since its acquisition by the Plan in 1983 is attributable to the bargain purchase price rather than any market factors. Having determined that the Plan should dispose of the Property, O'Connell represents that its purchase by the Employer would be in the Plan's best interests because it would ensure an immediate sale for cash, without any commissions or other expenses to the Plan in the amount of the Property's full appraised fair market value. In this regard, O'Connell notes that there are 20 other condominium units for sale in the 160-unit development containing the Property and that an attempted sale of the Property to an unrelated third party would take time (resulting in additional negative cash flow), may not generate all cash, would result in sales costs and commissions to the Plan, and may result in a purchase price below the appraised fair market value.

5. In summary, the Trustees represent that the proposed transaction satisfies the criteria of section 408(a) of the Act for the following reasons: (1) The interests of the Plan will be represented by O'Connell, an independent fiduciary who has determined that the proposed transaction is in the best interests of the Plan; (2) The Plan will receive the full appraised fair market value of the Property as of the date of the proposed sale; (3) The Plan will be paid cash for the Property and will not incur any commissions or other expenses related to the proposed sale transaction; and (4) The proposed transaction will enable the Plan to better diversify its assets by disposing of an asset which constitutes approximately 38 percent of the Plan's total assets.

*For Further Information Contact:* Mr. Ronald Willett of the Department, telephone (202) 523-8194. (This is not a toll-free number.)

**Foster L. Bullard, Jr., M.D., P.A. Pension Plan (the Plan) Located in Naples, Florida**

[Application No. D-6138]

*Proposed Exemption*

The Department is considering granting an exemption under the authority of section 408(a) of the Act and section 4975(c)(2) of the Code and in accordance with the procedures set forth in ERISA Procedure 75-1 (40 FR 18471, April 28, 1975). If the exemption is granted the restrictions of section 406(a) and 406(b)(1) and (b)(2) of the Act and the sanctions resulting from the application of section 4975 of the Code, by reason of section 4975(c)(1)(A) through (E) of the Code shall not apply to the proposed sale by the Plan of its beneficial interest (the Property) in the Lindgren Land Trust to Foster L. Bullard, Jr., M.D. (Dr. Bullard), a party in interest with respect to the Plan, provided that the sales price is not less than the fair market value of the Property on the date of sale.

*Summary of Facts and Representations*

1. The Plan is a defined benefit pension plan with seven participants and total assets of $970,729 as of October 31, 1984. The Plan is sponsored by the Foster L. Bullard, Jr., M.D., P.A. (the Employer), a Florida professional corporation engaged in a medical practice in Naples, Florida. The trustees of the Plan are Dr. Bullard and his office manager, Dwight Linn, (the Trustees).

2. The Property was originally purchased by the Foster L. Bullard, Jr., M.D., P.A. Money Purchase Pension Plan (the Money Purchase Plan) from an independent third party on February 6, 1973. The Money Purchase Plan was terminated effective November 1, 1984, and its assets, including the Property, were transferred to the Plan. The Property is a 2.5 percent interest in the Lindgren Land Trust (the Land Trust) which the applicant states has a cost basis of $55,003.84. The Land Trust owns two adjacent 88 acre parcels of unimproved land in Dade County, Florida which are subject to two mortgages (the Land). The applicant states that neither Dr. Bullard nor any other party in interest has any interest in the Land Trust. The applicant states further that the only assets of the Land Trust are the Land and the remaining payments on a $146,000 mortgage receivable.

3. The applicant represents that beginning in March, 1983, various proposals were submitted to the beneficial owners of the Land Trust, including the Plan, regarding the need to

obtain additional funds to improve the Land for resale or development. These proposals involved the possibility of obtaining land improvement and construction loans for commencement of construction of warehouses and office buildings. Mr. Richard Herzog, the plan administrator and investment manager for the Plan, states that under these circumstances continued ownership of the Property would not be in the Plan's best interest. Mr. Herzog states that since the original intent of the Land Trust was ownership of unimproved real estate, the Plan should not have to accept the risks commensurate with the development of the Land. These risks include the possiblity of the Plan incurring unrelated trade or business taxable income or the Plan becoming liable for any indebtedness that occurs as a result of development expenses. Further, Mr. Herzog states that interest costs on debt services currently being charged to the Land Trust are of no benefit to the Plan because the latter is a non-taxpaying entity which is unconcerned with maximizing tax deductions. Finally, costly annual appraisals are necessary to properly value the Property. Thus, the applicant concludes that the Property is an inappropriate investment for the Plan and is generally unmarketable.

4. The Land was appraised on March 18, 1985 by Edward M. Waronker, M.A.I. (Mr. Waronker), an independent real estate appraiser in Miami, Florida, as having a fair market value of $3,400,000. Dr. Bullard proposes to purchase the Property from the Plan in cash for the following amount: (a) 2.5 percent of the appraised value of the Land as evidenced by Mr. Waronker's appraisal (i.e. $85,000), and (b) 2.5 percent of the $146,00 mortgage receivable due the Land Trust in January 1986, prorated with respect to interest if the sale takes place prior to that time.

The mortgage receivable is a bond issued by Dade County as part of a purchase agreement with the Land Trust for the acquisition of 62.67 acres of land known as Tamiami Pineland. The last payment on the bond, including principal and interest, is due in 1986. The applicant represents that Dr. Bullard will reimburse the Plan for its share of the principal payment and accrued interest to the date of payment of the bond.

5. The applicant states that the Plan will pay no expenses, commissions, or fees in connection with the sale.

6. In summary, the applicant represents that the transaction satisfies the criteria of section 408(a) of the Act because: (a) The sale will be a one-time transaction for cash; (b) the Plan will receive the fair market value for the Property as determined by an independent qualified appraiser; (c) the Plan will not be required to pay any real estate fees or commissions in connection with the sale; and (d) Mr. Herzog, as the Plan's administrator and investment manager, has determined that it is in the Plan's best interest to sell the Property because of the risks associated with the development of the Land by the Land Trust.

For Further Information Contact: Mr. E.F. Williams of the Department, telephone (202) 523-8195. (This is not a toll-free number.)

**General Information**

The attention of interested persons is directed to the following:

(1) The fact that a transaction is the subject of an exemption under section 408(a) of the Act and/or section 4975(c)(2) of the Code does not relieve a fiduciary or other party in interest or disqualified person from certain other provisions of the Act and/or the Code, including any prohibited transaction provisions to which the exemption does not apply and the general fiduciary responsibility provision of section 404 or the Act, which among other things require a fiduciary to discharge his duties respecting the plan solely in the interest of the participants and beneficiaries of the plan and in a prudent fashion in accordance with section 404(a)(1)(B) of the Act; nor does it affect the requirement of section 401(a) of the Code that the plan must operate for the exclusive benefit of the employees of the employer maintaining the plan and their beneficiaries;

(2) Before an exemption may be granted under section 408(a) of the Act and/or section 4975(c)(2) of the Code, the department must find that the exemption is administratively feasible, in the interests of the plan and of its participants and beneficiaries and protective of the rights of participants and beneficiaries of the plan; and

(3) The proposed exemptions, if granted, will be supplemental to, and not in derogation of, any other provisions of the Act and/or the code, including statutory or administrative exemptions and transitional rules. Furthermore, the fact that a transaction is subject to an administrative or statutory exemption is not dispositive of whether the transaction is in fact a prohibited transaction.

(4) The proposed exemptions, if granted, will be subject to the express condition that the material facts and representations contained in each application are true and complete, and that each application accurately describes all material terms of the transaction which is the subject of the exemption.

Signed at Washington, D.C., this twenty-seventh day of August 1985.

**Elliot I. Daniel,**

*Assistant Administrator for Regulations and Interpretations, Office of Pension and Welfare Benefit Programs, U.S. Department of Labor.*

[FR Doc. 85-20878 Filed 8-30-85; 8:45 am]

BILLING CODE 4510-29-M

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**[Prohibited Transaction Exemption 85-138; Exemption Application No. D-4585 et al.]**

## Grant of Individual Exemptions; Gibson Products, Co., Inc., et al.

**AGENCY:** Pension and Welfare Benefit Programs, Labor.

**ACTION:** Grant of Individual Exemptions.

**SUMMARY:** This document contains exemptions issued by the Department of Labor (the Department) from certain of the prohibited transaction restrictions of the Employee Retirement Income Security Act of 1974 (the Act) and/or the Internal Revenue Code of 1954 (the Code).

Notices were published in the **Federal Register** of the pendency before the Department of proposals to grant such exemptions. The notices set forth a summary of facts and representations contained in each application for exemption and referred interested persons to the respective applications for a complete statement of the facts and representations. The applications have been available for public inspection at the Department in Washington, D.C. The notices also invited interested persons to submit comments on the requested exemptions to the Department. In addition the notices states that any interested person might submit a written request that a public hearing be held (where appropriate). The applicants have represented that they have complied with the requirements of the notification to interested persons. No public comments and no requests for a hearing, unless otherwise stated, were received by the Department.

The notices of pendency were issued and the exemptions are being granted solely by the Department because, effective December 31, 1978, section 102 of Reorganization Plan No. 4 of 1978 (43 FR 47713, October 17, 1978) transferred the authority of the Secretary of the Treasury to issue exemptions of the type proposed to the Secretary of Labor.

*Statutory Findings*

In accordance with section 408(a) of the Act and/or section 4975(c)(2) of the Code and the procedures set forth in ERISA Procedure 75–1 (40 FR 18471, April 28, 1975), and based upon the entire record, the Department makes the following findings:

(a) The exemptions are administratively feasible;

(b) They are in the interests of the plans and their participants and beneficiaries; and

(c) They are protective of the rights of the participants and beneficiaries of the plans.

**Gibson Products Company, Inc. Employees Profit Sharing Plan Located in Sherman, Texas (the Plan)**

[Prohibited Transaction Exemption 85–138; Exemption Application No. D–4585]

*Exemption*

The restrictions of section 406(a) and 406 (b)(1) and (b)(2) of the Act and the sanctions resulting from the application of section 4975 of the Code, by reason of section 4975(c)(1) (A) through (E) of the Code, shall not apply to the sale of a 15 acre parcel of real property located in Grayson County Texas (the Property) by the Plan to Ms. Diane Loving and Mr. Gary Acklin, parties in interest with respect to the Plan, for $80,000 in cash, representing the fair market value of the Property, plus accrued earnings, provided such amount is not less than the fair market value of the Property on the date of the sale.

For a more complete statement of the facts and rperesentations supporting the Department's decision to grant this exemption refer to the notice of proposed exemption published on June 18, 1985, at 50 FR 25346.

*For Further Information Contact:* Ms. Linda M. Hamilton of the Department, telephone (202) 523–8881. (This is not a toll-free number.)

**Local 725 Pension Trust Fund of Dade, Broward and Monroe Counties, FL (the Pension Plan) and Local 725 Educational Trust Fund of Dade, Broward and Monroe Counties, FL (the Educational Plan) Located in Coral Gables, FL**

[Prohibited Transaction Exemption 85–139; Exemption Application Nos. D–5072 and D–5073]

*Exemption*

The restrictions of section 406(b)(2) of the Act shall not apply to the continuation of a loan by the Pension Plan to the Educational Plan, provided that the terms and conditions of the loan were and will remain at least arm's-length.

For a more complete statement of the facts and representations supporting the Department's decision to grant this exemption refer to the notice of proposed exemption published on June 18, 1985 at 50 FR 25348.

*Effective date:* This exemption is effective July 1, 1984.

*For Further Information Contact:* Mr. Alan Levitas of the Department, telephone (202) 523–8971. (This is not a toll-free number.)

**Farmers National Bank of Webster City Profit Sharing Plan (the Plan) Located in Webster City, Iowa**

[Prohibited Transaction Exemption 85–140; Exemption Application No. D–5909]

*Exemption*

The restrictions of section 406(a) and 406 (b)(1) and (b)(2) of the Act and the sanctions resulting from the application of section 4975 of the Code, by reason of section 4975(c)(1) (A) through (E) of the Code, shall not apply to the purchase of participations in loans by the Plan from Commercial State Bank of Pocahontas, Iowa, a party in interest with respect to the Plan, for a period of five years from the date of this exemption, provided that the terms of the transactions are not less favorable to the Plan than the terms generally available in arm's-length transactions between unrelated parties.

For more complete statement of the facts and representations supporting the Department's decision to grant this exemption refer to the notice of proposed exemption published on April 17, 1985 at 50 FR 15246.

*Written Comments:* The Department received two written comments on the proposed transaction, both opposing the transaction. Only one of the comments raised a substantive issue, however, which was that the nature of Iowa's depressed farm economy made this transaction an inappropriate Plan investment. Valley National Bank, the Plan trustee (the Trustee), represented that it would review each loan participation on its own merits and would have to be satisfied that the credit risk involved is reasonable in relation to: (1) The rate of return; and (2) the composition of the the rest of the Plan's investment portfolio. If the Trustee foresees an unacceptable credit risk, it will not purchase participations.

Accordingly, after consideration of the entire record, the Department has conclude that the exemption be granted as proposed.

*Temporary Nature of Exemption*

This exemption will be temporary in nature and will expire 5 years from the date of this grant with respect to the acquisition of participations from Commercial.

*For Further Information Contact:* David Lurie of the Department, telephone (202) 523–8884. (This is not a toll free number.)

**George L. Nadler, D.D.S., P.C. Defined Benefit Pension Plan (the Plan) Located in Tucson, Arizona**

[Prohibited Transaction Exemption 85–141; Exemption Application No. D–5949]

*Exemption*

The restrictions of section 406(a) and 406 (b)(1) and (b)(2) of the Act and the sanctions resulting from the application of section 4975 of the Code, by reason of section 4975(c)(1) (A) through (E) of the Code, shall not apply to the sale by the Plan of a certain parcel of unimproved real property (the Property) located in Tucson, Arizona to George L. Nadler, D.D.S., the sole shareholder of George L. Nadler, D.D.S., P.C., and the Plan trustee, for $100,000 in cash, provided that such price is not less than the fair market value of the Property as of the date of sale.

For a more complete statement of the facts and representations supporting the Department's decision to grant this exemption refer to the notice of proposed exemption published on May 3, 1985 at 50 FR 18948.

In the published notice, the first sentence in representation number 5 was in error and should read as follows:

5. The applicant, however, represents that, "there is reason to believe the Property will not appreciate significantly in value over the next five years, and that the combination of growth and cash outlay for expenses will likely result in a net-loss for the Plan during this period."

*For Further Information Contact:* David Lurie of the Department, telephone (202) 523–8884. (This is not a toll-free number).

**Laney & Duke Storage Warehouse Company Employee Profit Sharing and Trust, Laney & Duke Terminal Warehouse Company, Inc., Employee Profit Sharing Plan and Trust (collectively, the Plans) Located in Jacksonville, Florida**

[Prohibited Transition Exemption 85–142; Exemption Application No. D–5965 and D–5966]

*Exemption*

The restrictions of section 406(a) and 406 (b)(1) and (b)(2) of the Act and the sanctions resulting from the application of section 4975 of the Code, by reason of section 4975(c)(1) (A) through (E) of the

Code, shall not apply to the cash sale of certain parcels of real property (the Property) by the Plans to Laney & Duke Terminal Warehouse Company, Inc., a party in interest with respect to the Plans, provided that the sale price of the Property is not less than the higher of either $2,709,500 or the fair market value on the date of the sale.

For a more complete statement of the facts and representations supporting the Department's decision to grant this exemption refer to the notice of proposed exemption published on June 18, 1985, at 50 FR 25349.

*Effective Date:* The effective date of the exemption is June 20, 1985.

*Written Comments:* The only comment received by the Department was from the applicants, Laney & Duke Storage Warehouse Company and Laney & Duke Terminal Warehouse Company, Inc. The applicants state that the transaction was consummated on June 20, 1985, and therefore, they request that the exemption be granted effective June 20, 1985.

After consideration of the entire record the Department has determined to grant the exemption effective June 20, 1985.

*For Further Information Contact:* Mr. C.E. Beaver of the Department, telephone (202) 523-7901. (This is not a toll-free number.)

**Thomas R. Williams Self-Employed Defined Benefit Retirement Plan (the Plan) Located in Atlanta, Georgia**

[Prohibited Transaction Exemption 85-143; Exemption Application No. D-6129]

*Exemption*

The sanctions resulting from the application of section 4975 of the Code, by reason of section 4975(c)(1) (A) through (E) of the Code, shall not apply to the proposed contributions of common stock of First Atlanta Corporation to the Plan by Mr. Thomas R. Williams (Mr. Williams),[1] the Plan's sponsor, provided that the terms and conditions of each proposed contribution is no less favorable to the Plan than those available in an arm's-length transaction with an unrelated party.

For a more complete statement of the facts and representations supporting the Department's decision to grant this exemption refer to the notice of proposed exemption published on July 8, 1985 at 50 FR 27862.

[1] Since Mr. Williams is the only participant in the Plan there is no jurisdiction under Title 1 of the Act pursuant to 29 CFR 2510.3-3(b). However, there is jurisdiction under Title II of the Act pursuant to section 4975 of the Code.

*For Further Information Contact:* Alan H. Levitas of the Department, telephone (202) 523-8971. (This is not a toll-free number.)

**General Information**

The attention of interested persons is directed to the following:

(1) The fact that a transaction is the subject of an exemption under section 408(a) of the Act and/or section 4975(c)(2) of the Code does not relieve a fiduciary or other party in interest or disqualified person from certain other provisions of the Act and/or the Code, including any prohibited transaction provisions to which the exemption does not apply and the general fiduciary responsibility provisions of section 404 of the Act, which among other things require a fiduciary to discharge his duties respecting the plan solely in the interest of the participants and beneficiaries of the plan and in a prudent fashion in accordance with section 404(a)(1)(B) of the Act; nor does it affect the requirement of section 401(a) of the Code that the plan must operate for the exclusive benefit of the employees of the employer maintaining the plan and their beneficiaries;

(2) These exemptions are supplemental to and not in derogation of, any other provisions of the Act and/or the Code, including statutory or administrative exemptions and transitional rules. Furthermore, the fact that a transaction is subject to an administrative or statutory exemption is not dispositive of whether the transaction is in fact a prohibited transaction.

(3) The availability of these exemptions is subject to the express condition that the material facts and representations contained in each application accurately describes all material terms of the transaction which is the subject of the exemption.

Signed at Washington, D.C. this twenty-seventh day of August 1985.

**Elliot I. Daniel,**

*Assistant Administrator for Regulations and Interpretations, Office of Pension and Welfare Benefit Programs, U.S. Department of Labor.*

[FR Doc. 85-20879 Filed 8-30-85; 8:45 am]

BILLING CODE 4510-29-M

## NUCLEAR REGULATORY COMMISSION

### Draft Regulatory Guide; Issuance, Availability

The Nuclear Regulatory Commission has issued for public comment a draft of a proposed revision to a guide in its Regulatory Guide Series together with a draft of the associated value/impact statement. This series has been developed to describe and make available to the public methods acceptable to the NRC staff of implementing specific parts of the Commission's regulations and, in some cases, to delineate techniques used by the staff in evaluating specific problems or postulated accidents and to provide guidance to applicants concerning certain of the information needed by the staff in its review of applications for permits and licenses.

The draft, temporarily identified by its task number, FC 415-4 (which should be mentioned in all correspondence concerning this draft guide), is proposed Revision 2 to Regulatory Guide 10.8 and is entitled "Guide for the Preparation of Applications for Medical Programs." The guide is being developed to provide guidance in conformance with the revised NRC Form 313 for preparing license applications for medical programs. This draft guide also conforms to the proposed revision of 10 CFR Part 35, "Medical Use of Byproduct Material," that the Commission published for comment in the **Federal Register** on July 26, 1985 (50 FR 30616).

This draft guide and the associated value/impact statement are being issued to involve the public in the early stages of the development of a regulatory position in this area. They have not received complete staff review and do not represent an official NRC staff position.

Public comments are being solicited on both drafts, the guide (including any implementation schedule) and the draft value/impact statement. Comments on the draft value/impact statement should be accompanied by supporting data. Comments on both drafts should be sent to the Secretary of the Commission, U.S. Nuclear Regulatory Commission, Washington, DC 20555, Attention: Docketing and Service Branch, by November 18, 1985.

Although a time limit is given for comments on these drafts, comments and suggestions in connection with: (1) Items for inclusion in guides currently being developed or (2) improvements in all published guides are encouraged at any time.

Regulatory guides are available for inspection at the Commission's Public Document Room, 1717 H Street NW., Washington, D.C. Requests for single copies of draft guides (which may be reproduced) or for placement on an automatic distribution list for single copies of future draft guides in specific divisions should be made in writing to

the U.S. Nuclear Regulatory Commission, Washington, DC 20555, Attention: Director, Division of Technical Information and Document Control. Telephone requests cannot be accommodated. Regulatory guides are not copyrighted, and Commission approval is not required to reproduce them.

(5 U.S.C. 552(a))

Dated at Silver Spring, Maryland, this 26th day of August, 1985.

For the Nuclear Regulatory Commission.

**Robert B. Minogue,**

*Director, Office of Nuclear Regulatory Research.*

[FR Doc. 85-20975 Filed 8-30-85; 8:45 am]

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[Docket No. 50-323]

## Diablo Canyon Nuclear Power Plant, Unit 2, Pacific Gas Electric Co.; Issuance of Facility Operating License DPR-82

Notice is hereby given that, pursuant to the approval given in a Memorandum and Order dated August 1, 1985, the U.S. Nuclear Regulatory Commission (the Commission) has issued Facility Operating License No. DPR-82 (the licensee) to Pacific Gas and Electric Company (PG&E or the license) which authorizes operation of the Diablo Canyon Nuclear Power Plant, Unit 2 (the facility or Diablo Canyon Unit 2). Diablo Canyon, Unit 2 is a pressurized water reactor located in San Luis Obispo County, California. This license authroizes operation at reactor core power levels not in excess of 3411 megawatts thermal (100% rated power) in accordance with the provisions of the license, the Technical Specifications and the Environmental Protection Plan. Facility Operating License No. DPR-82 supersedes Facility Operating License No. DPR-81, previously issued to the licensee on April 26, 1985, which authorized the operation of the facility at power levels up to 5% of rated power.

The application for license complies with the standards and requirements of the Atomic Energy Act of 1954, as amended (the Act), and the Commission's regulations. The Commission has made appropriate findings as required by the Act and the Commission's regulations in 10 CFR Chapter I, which are set forth in the license. Prior public notice of the overall action involving the proposed issuance of an operating license authorizing full power operation was publiched in the **Federal Register** on October 19, 1973 (38 FR 29105).

The Commission has determined that the issuance of this License will not result in any environmental impacts other than those evaluated in the Final Environmental Statement (issued in May 1973, 38 FR 14183) and its Addendum (issued in May 1976, 41 FR 22895), the NRC Flood Plain Review (dated September 9, 1981) and the NRC Discussion of Environmental Effects of the Uranium Fuel Cycle (dated September 9, 1981) since the activity authorized by this License is encompassed by the overall action evaluated in those documents.

For further details with respect to this action, see (1) Commission Memorandum and Order (CL1-85-14) dated August 1, 1985; (2) Facility Operating License No. DPR-82 with Technical Specifications (NUREG-1151) and the Environmental Protection Plan; (3) Facility Operating License No. DPR-81 for fuel load and low power dated April 26, 1985; (4) the reports of the Advisory Committee on Reactor Safeguards dated June 12, 1975, August 19, 1977, July 14, 1978, November 12, 1980, February 14, 1984, April 9, 1984, June 20, 1984 and July 16, 1984; (5) the Commission's Safety Evaluation Report (NUREG-0675, Supplements No. 1 through No. 32); (6) the Final Environmental Statement dated May 1973 and its Addendum dated May 1976; (7) NRC Flood Plain Review of Diablo Canyon Nuclear Power Plant Site dated September 9, 1981; and (8) Discussion of the Environmental Effects of Uranium Fuel Cycle dated September 9, 1981. These items are available for public inspection at the Commission's Public Document Room, 1717 H Street, NW., Washington, D.C. and the California Polytechnic State University Library, Documents and Maps Department, San Luis Obispo, California 93407. A copy of the Facility Operating License No. DPR-82 may be obtained upon request addressed to the U.S. Nuclear Regulatory Commission, Washington, D.C. 20555, Attention: Director, Division of Licensing. Copies of NUREG-0675, NUREG-1151 and the Final Environmental Statement and its Addendum may be purchased from the National Technical Information Service, Department of Commerce, 5285 Port Royal Road, Springfield, VA 22161, or may be ordered by calling (202) 275-2060 or (202) 275-2171 or by writing to the Superintendent of Documents, U.S. Government Printing Office, Post Office Box 37082, Washington, D.C. 20013-7082. All orders should clearly identify the NRC publication number and the requester's GPO deposit account, or Visa or Mastercard number and expiration date.

Dated at Bethesda, Maryland, the 26 day of August, 1985.

For The Nuclear Regulatory Commission.

**George W. Knighton,**

*Chief, Licensing Branch No. 3, Division of Licensing.*

[FR Doc. 85-20973 Filed 8-30-85; 8:45 am]

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[Docket No. 50-483]

## Union Electric Co.; Consideration of Issuance of Amendment to Facility Operating License and Proposed no Significant Hazards Consideration Determination and Opportunity for Hearing

The United States Nuclear Regulatory Commission (the Commission) is considering issuance of an amendment to Facility Operating License No. NPF-30, issued to Union Electric Company, for operation of the Callaway Plant, Unit 1 located in Callaway County, Missouri.

The purpose of the proposed amendment is to provide an extension of the initial 18-month surveillance interval on the following items:

1. Manual Initiations for Reactor Trip System and Engineered Safety Features Actuation System (ESFAS),
2. Portions of Diesel Generator Testing,
3. ESFAS Actuations on Safety Injection and Loss-of-offsite Power,
4. Containment Spray Actuation Testing,
5. Phase A and B Containment Isolations,
6. Class 1E Battery Service Test.

The requested change would allow the surveillance interval for these surveillances to be extended beyond that allowed by the technical specifications until startup following the first refueling outage or June 1, 1986, whichever occurs first, in accordance with the licensee's request dated July 10, 1985 as supplemented by letter dated August 9, 1985. The first refueling outage is the next scheduled shutdown and is currently scheduled to begin in April, 1986. This request entails an approximate six-month extension in the most limiting case.

Normally, since refueling outages occur about every 18-months, extensions beyond the 18-month surveillance interval required by the technical specifications for these items are usually not necessary. However, due to the extended length of the plant startup program and cycle 1, the licensee must either request an extension or be forced to shutdown prior to the first refueling outage.

Before issuance of the proposed license amendment, the Commission will have made findings required by the Atomic Energy Act of 1954, as amended (the Act) and the Commission's regulations.

The Commission has made a proposed determination that the amendment request involves no significant hazards consideration. Under the Commission's regulations in 10 CFR 50.92, this means that operation of the facility in accordance with the proposed amendment would not: (1) Involve a significant increase in the probability or consequences of an accident previously evaluated; or (2) create the possibility of a new or different kind of accident from any accident previously evaluated; or (3) involve a significant reduction in a margin of safety.

The licensee's amendment application considers that the extensions requested are justified based on a combination of preoperational test results, surveillances that are current into Refuel 1, surveillances that are periodically performed at power, and system performance verification following two operational occurrences. The following discussions address each of the parts of the amendment request and provide an analysis using the standards of 10 CFR 50.92.

The change to Technical Specification 4.3.1.1–17 regarding safety injection input from the engineered safety features actuation system does not involve a significant increase in the probability or consequences of an accident previously evaluated. The equipment tested by this surveillance is safety-related and highly reliable. In addition because of overlap testing, all portions of this circuit are tested in other surveillance tests with the exception of the control board manual switches as described in the next paragraph. This change does not create the possibility of a new or different kind of accident from any accident previously evaluated. This is based on the fact that no design change is involved and the method and manner of plant operations is unchanged. This change does not involve a significant reduction in a margin of safety since the plant design bases, safety limits, limiting safety system settings, and limiting conditions for operation remain unchanged.

The change to Technical Specification 4.3.2.1–1.a regarding manual initiation of safety injection (SI) does not involve a significant increase in the probability or consequences of an accident previously evaluated. The equipment tested by this surveillance is safety-related and highly reliable. Based on system performance verification following an operational occurrence (SI) on 3/30/85 and through the process of overlap testing, all portions of this circuit have been exercised within the past 18 months with the exception of the control board manual switches. These control board switches and their contacts require no calibration, are not required to respond to setpoints and have historically exhibited a low failure rate. This change does not create the possibility of a new or different kind of accident from any accident previously evaluated. This is based on the fact that no design change is involved and the method and manner of plant operations is unchanged. This change does not involve a significant reduction in a margin of safety since the plant design bases, safety limits, limiting safety system settings, and limiting conditions for operation remain unchanged.

The changes to Technical Specifications 4.3.2.1–2.a and 4.3.2.1–3.b.1) regarding manual initiations of containment spray and phase B isolation, respectively, do not involve a significant increase in the probability or consequences of an accident previously evaluated. The equipment tested by these surveillances is safety-related and highly reliable. In addition because of overlap testing, all portions of these circuits are tested in other surveillance tests with the exception of the control board manual switches and the load sequencer output relay driver cards between the load sequencer and the containment spray pumps. In this case simultaneous depression of two switches is required for actuation which results in both containment spray actuation and phase B isolation. These control board switches and their contacts require no calibration, are not required to respond to setpoints and have historically exhibited a low failure rate. This change does not create the possibility of a new or different kind of accident from any accident previously evaluated. This is based on the fact that no design change is involved and the method and manner of plant operations is unchanged. This change does not involve a significant reduction in a margin of safety since the plant design bases, safety limits, limiting safety system settings, and limiting conditions for operation remain unchanged.

The change to Technical Specification 4.5.2.e.2) regarding emergency core cooling system actuation on a safety injection signal does not involve a significant increase in the probability or consequences of an accident previously evaluated. This is based on system performance verification following an operational occurrence (SI) on 3/30/85 and through the process of overlap testing.

This change does not create the possibility of a new or different kind of accident from any accident previously evaluated. This is based on the fact that no design change is involved and the method and manner of plant operations is unchanged. This change does not involve a significant reduction in a margin of safety since the plant design bases, safety limits, limiting safety system settings, and limiting conditions for operation remain unchanged.

The change to Technical Specification 4.6.2.1.c.2) regarding the containment spray actuation test does not involve a significant increase in the probability or consequences of an accident previously evaluated. Through the process of overlap testing, each of the components in this circuit is tested on a periodic basis between 18-month test intervals, with the exception of the load sequencer output relay driver cards. This change does not create the possibility of a new or different kind of accident from any accident previously evaluated. This is based on the fact that no design change is involved and the method and manner of plant operations is unchanged. This change does not involve a significant reduction in a margin of safety since the plant design bases, safety limits, limiting safety system settings, and limiting conditions for operation remain unchanged.

The change to Technical Specificiations 4.6.3.2.a and 4.6.3.2.b regarding phase A and phase B isolation tests, respectively, do not involve a significant increase in the probability or consequences of an accident previously evaluated. This is based on system performance verification following an operational occurrence (SI) on 3/30/85 which exercised phase A and for phases A and B through the process of overlap testing. This change does not create the possibility of a new or different kind of accident from any accident previously evaluated. This is based on the fact that no design change is involved and the method and manner of plant operations is unchanged. This change does not involve a significant reduction in a margin of safety since the plant design bases, safety limits, limiting safety system settings, and limiting conditions for operation remain unchanged.

The change to Technical Specification 4.7.3.b.2) regarding component cooling water actuation on a safety injection signal does not involve a significant increase in the probability or consequences of an accident previously evaluated. This is based on system performance verification following an

operational occurrence (SI) on 3/30/85 and through the process of overlap testing. This change does not create the possibility of a new or different kind of accident from any accident previously evaluated. This is based on the fact that no design change is involved and the method and manner of plant operations is unchanged. This change does not involve a significant reduction in a margin of safety since the plant design bases, safety limits, limiting safety system settings, and limiting conditions for operation remain unchanged.

The change to Technical Specification 4.7.4.b.2) regarding essential service water actuation on a safety injection signal does not involve a significant increase in the probability or consequences of an accident previously evaluated. This is based on system performance verification following an operational occurrence (SI) on 3/30/85 and through the process of overlap testing. This change does not create the possibility of a new or different kind of accident from any accident previously evaluated. This is based on the fact that no design change is involved and the method and manner of plant operations is unchanged. This change does not involve a significant reduction in a margin of safety since the plant design bases, safety limits, limiting safety system settings, and limiting conditions for operation remain unchanged.

The change to Technical Specification 4.8.1.1.2.f regarding diesel generator testing does not involve a significant increase in the probability or consequences of an accident previously evaluated. This is based on performance of monthly diesel surveillances and portions of the 18-month diesel surveillance test which are current into Refuel 1 [i.e., 4.8.1.1.2.f.1), and 11)]; system performance verification following two operational occurrences; overlap testing of components; and previous operational history of the Callaway diesels. This change does not create the possibility of a new or different kind of accident from any accident previously evaluated. This is based on the fact that no design change is involved and the method and manner of plant operations is unchanged. This change does not involve a significant reduction in a margin of safety since the plant design bases, safety limits, limiting safety system settings, and limiting conditions for operation remain unchanged.

The change to Technical Specification 4.8.2.1.d regarding battery service testing does not involve a significant increase in the probability or consequences of an accident previously evaluated. This is based on performance of the batteries during preoperational testing; the fact that no substantial loads have been added to the batteries since the preoperational tests; Callaway is in its first cycle of operation and the batteries are relatively new; and weekly or quarterly battery surveillances which look at electrolyte level, float voltage, specific gravity, total battery terminal voltage, visible corrosion, terminal connection resistance and electrolyte temperature. This change does not create the possibility of a new or different kind of accident from any accident previously evaluated. This is based on the fact that no design is involved and the method and manner of plant operations is unchanged. This change does not involve a significant reduction in a margin of safety since the plant design bases, safety limits, limiting safety system settings, and limiting conditions for operation remain unchanged.

On the above mentioned bases, the staff proposes to determine that this amendment, which provides an extension of the initial 18-month surveillance intervals on the above mentioned items, does not involve significant hazards considerations.

The Commission is seeking public comments on this proposed determination. Any comments received within 30 days after the date of publication of this notice will be considered in making any final determination. The Commission will not normally make a final determination unless it receives a request for a hearing.

Comments should be addressed to the Secretary of the Commission, U.S. Nuclear Regulatory Commission, Washington, D.C. 20555, Attn: Docketing and Service Branch.

By October 3, 1985 the licensee may file a request for a hearing with respect to issuance of the amendment to the subject facility operating license and any person whose interest may be affected by this proceeding and who wishes to participate as a party in the proceeding must file a written petition for leave to intervene. A request for a hearing and petitions for leave to intervene shall be filed in accordance with the Commission's "Rules of Practice for Domestic Licensing Proceedings" in 10 CFR Part 2. If a request for a hearing or petition for leave to intervene is filed by the above date, the Commission or an Atomic Safety and Licensing Board, designated by the Commission or by the Chairman of the Atomic Safety and Licensing Board Panel, will rule on the request and/or petition and the Secretary or the designated Atomic Safety and Licensing Board will issue a notice of hearing or an appropriate order.

As required by 10 CFR 2.714, a petition for leave to intervene shall set forth with particularity the interest of the petitioner in the proceeding, and how that interest may be affected by the results of the proceeding. The petition should specifically explain the reasons why intervention should be permitted with particular reference to the following factors: (1) The nature of the petitioner's right under the Act to be made a party to the proceeding; (2) the nature and extent of the petitioner's property, financial, or other interest in the proceeding; and (3) the possible effect of any order which may be entered in the proceeding on the petitioner's interest. The petition should also identify the specific aspects of the subject matter of the proceeding as to which petitioner wishes to intervene. Any person who has filed a petition for leave to intervene or who has been admitted as a party may amend the petition without requesting leave of the Board up to fifteen (15) days prior to the first prehearing conference scheduled in the proceeding, but such an amended petition must satisfy the specificity requirements described above.

Not later than fifteen (15) days prior to the first prehearing conference scheduled in the proceeding, a petitioner shall file a supplement to the petition to intervene which must include a list of the contentions which are sought to be litigated in the matter, and the bases for each contention set forth with reasonable specificity. Contentions shall be limited to matters within the scope of the amendment under consideration. A petitioner who fails to file such a supplement which satisfies these requirements with respect to at least one contention will not be permitted to participate as a party.

Those permitted to intervene become parties to the proceeding, subject to any limitations in the order granting leave to intervene, and have the opportunity to participate fully in the conduct of the hearing, including the opportunity to present evidence and cross-examine witnesses.

If a hearing is requested, the Commission will make a final determination on the issue of no significant hazards consideration. The final determination will serve to decide when the hearing is held.

If the final determination is that the amendment request involves no significant hazards consideration, the Commission may issue the amendment

and make it effective, notwithstanding the request for a hearing. Any hearing held would take place after issuance of the amendment.

If the final determination is that the amendment involves a significant hazards consideration, any hearing held would take place before the issuance of any amendment.

Normally, the Commission will not issue the amendment until the expiration of the 30-day notice period. However, should circumstances change during the notice period such that failure to act in a timely way would result, for example, in derating or shutdown of the facility, the Commission may issue the license amendment before the expiration of the 30-day notice period, provided that its final determination is that the amendment involves no significant hazards consideration. The final determination will consider all public and State comments received. Should the Commission take this action, it will publish a notice of issuance and provide for opportunity for a hearing after issuance. The Commission expects that the need to take this action will occur very infrequently.

A request for a hearing or a petition for leave to intervene must be filed with the Secretary of the Commission, U.S. Nuclear Regulatory Commission, Washington, D.C. 20555, Attention: Docketing and Service Branch, or may be delivered to the Commission's Public Document Room, 1717 H Street, NW., Washington, D.C., by the above date. Where petitions are filed during the last ten (10) days of the notice period, it is requested that the petitioner promptly so inform the Commission by a toll-free telephone call to Western Union at (800) 325-6000 [in Missouri (800) 342-6700]. The Western Union operator should be given Datagram Identification Number 3737 and the following message addressed to B. J. Youngblood: petitioner's name and telephone number; date petition was mailed; plant name; and publication date and page number of this Federal Register notice. A copy of the petition should also be sent to the Executive Legal Director, U.S. Nuclear Regulatory Commission, Washington, D.C. 20555, and to Gerald Charnoff, Esquire, Shaw, Pittman, Potts & Trowbridge, 1800 M Street, N.W., Washington, D.C. 20036, attorney for the licensee.

Nontimely filings of petitions for leave to intervene, amended petitions, supplemental petitions and/or requests for hearing will not be entertained absent a determination by the Commission, the presiding officer or the Atomic Safety and Licensing Board designated to rule on the petition and/or request, that the petitioner has made a substantial showing of good cause for the granting of a late petition and/or request. That determination will be based upon a balancing of the factors specified in 10 CFR 2.714(a)(1)(i)–(v) and 2.714(d).

For further details with respect to this action, see the application for amendment which is available for public inspection at the Commission's Public Document Room, 1717 H Street, NW., Washington, D.C., and at the Fulton City Library, 709 Market Street, Fulton, Missouri 65251 and the Olin Library of Washington University, Skinker and Lindell Boulevards, St. Louis, Missouri 63130.

Dated at Bethesda, Maryland, this 27th day of August 1985.

For the Nuclear Regulatory Commission.

**B.J. Youngblood,**

*Chief, Licensing Branch No. 1, Division of Licensing.*

[FR Doc. 85-20974 Filed 8-30-85; 8:45 am]

BILLING CODE 7590-01-M

## PACIFIC NORTHWEST ELECTRIC POWER AND CONSERVATION PLANNING COUNCIL

### Mainstem Passage Advisory Committee; Meeting

**AGENCY:** Mainstem Passage Advisory Committee of the Pacific Northwest Electric Power and Conservation Planning Council (Northwest Power Planning Council).

**ACTION:** Notice of meeting to be held pursuant to the Federal Advisory Committee Act, 5 U.S.C. Appendix I, 1–4. Activities will include:

- Committee charter and role
- Interim spill at Corps dams
- Other
- Public comment

**STATUS:** Open.

**SUMMARY:** The Northwest Power Planning Council hereby announces a forthcoming meeting of its Mainstem Passage Advisory Committee.

**DATE:** September 4, 1985, 9:30 a.m.

**ADDRESS:** Meeting will be held in the Council's Meeting Room, 850 SW. Broadway, Suite 1100, Portland, Oregon.

**FOR FURTHER INFORMATION CONTACT:** Peter Paquet, 503-222-5161

**Edward Sheets,**

*Executive Director.*

[FR Doc. 85-20904 Filed 8-30-85; 8:45 am]

BILLING CODE 0000-00-M

## POSTAL RATE COMMISSION

[Order No. 627]

### Commission Notice and Order Concerning Filing of Petition of United Parcel Service for Study of Costing Methods and Establishing Time for Comments

Issued: August 27, 1985.

Before Commissioners: Janet D. Steiger, Chairman; Henry R. Folsom, Vice-Chairman; John W. Crutcher; James H. Duffy; Bonnie Guiton.

On August 22, 1985, United Parcel Service (UPS) filed a petition requesting that we "initiate a rulemaking proceeding to study costing methods" in a number of areas. The topics include: (1) The new costing system for purchased transportation that the Postal Service said it was developing, (2) the distribution of purchased transportation costs to the various zones for zone-rated subclasses, (3) variability of waking route time, (4) driving time on park-and-loop routes, (5) the appropriate type of analysis for coverage-related variability, (6) the variability of retrace time, (7) possible instrumentation bias in developing elemental load time variability, (8) treating collection time with its own variability analysis, separate from other street-support activities, (9) whether time spent by city carriers conversing with customers should be assigned to route time or found to be partially variable, (10) whether "other" vehicle driving time should be included in the street support analysis, and (11) whether additional analysis would permit the attribution of a larger percent of the costs for vehicle service drivers.

Any person wishing to comment on the desirability of instituting some type of proceeding on the August 22, 1985, UPS filing may do so within 21 days of the publication of this Notice and Order. The UPS filing is available at the Commission offices, 1333 H Street, NW., Washington, D.C. 20268. Parties should be aware that in any such procedure the Commission reserves the right to raise other costing issues including, for example, those addressed in Docket No. R84-1 at pages 131-41, and Appendices J and K, as well as those that may be raised by other parties.

The Commission orders:

(A) Comments are due 21 days after the publication of this Notice and Order in the Federal Register.

(B) The Secretary shall publish this Notice and Order in the Federal Register.

By the Commission.

**Charles L. Clapp,**

*Secretary.*

[FR Doc. 85-20845 Filed 8-30-85; 8:45 am]

BILLING CODE 7715-01-M

## PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

### Meeting

Notice is hereby given of a meeting of the Prospective Payment Assessment Commission scheduled for Thursday, September 19, 1985. The meeting will convene at 10:00 a.m. in the Executive Room of the Shoreham Hotel, 2500 Calvert Street and Connecticut Avenue, Northwest, Washington, D.C. The meeting is open to the public.

**Donald A. Young, MD,**

*Executive Director.*

[FR Doc. 85-20862 Filed 8-30-85; 8:45 am]

BILLING CODE 6820-BW-M

## SECURITIES AND EXCHANGE COMMISSION

**[Release No. 35-23804; 31-807]**

### Castle & Cooke, Inc.; Application To Be Declared Not To Be an Electric Utility Co.

August 26, 1985.

Castle & Cooke, Inc. ("C&C"), a Hawaii Corporation, P.O. Box 7330, 50 California Street, San Francisco, California 94120-7330, has filed an application on May 28, 1985 requesting an order of the Commission declaring that C&C is not an electric utility company pursuant to section 2(a)(3) of the Public Utility Holding Company Act of 1935 ("Act").

According to the application, C&C is engaged primarily in the worldwide sourcing, processing, distributing and marketing of branded food products. In addition, C&C, both directly and through its wholly-owned subsidiary Oceanic Properties, Inc., has extensive real estate holdings, primarily in Hawaii and California, a substantial portion of which are dedicated to C&C's agricultural production operations. The application states that C&C owns and operates five diesel generators located on the island of Lanai, where it owns 98% of the island's acreage. These generators supply electricity to the pineapple operations of C&C's Dole operating division. C&C also uses the generators to provide electric power to Maui Electric Company ("MECO"), which owns and operates the retail electricity distribution systems on both Lanai and its neighboring island of Maui.

According to the application, the electricity received by MECO from C&C is sold by MECO to its retail customers on Lanai, and the rates for those sales are regulated by the Public Utilities Commission of the State of Hawaii ("Hawaii PUC"). C&C has never been required to be certificated as a public utility by the Hawaii PUC, which has not asserted regulatory jurisdiction over C&C by reason of C&C's electricity generation operations. However, the Hawaii PUC requires MECO to obtain approval of the terms of its Purchase Power Agreement ("the Agreement") with C&C and in connection with its review of the contract, requires the submission of data which substantiates the price for power provided in the Agreement. The Agreement requires C&C to supply electricity sufficient to meet a maximum load of 2200 kilowatts. C&C maintains five diesel generators with a total name plate capacity of 4,060 kilowatts. In 1984, Dole took delivery of 5,038,107 kilowatt hours and MECO purchased 6,066,065 kilowatt hours. C&C's total revenues of $755,092.00 from its sales to MECO constituted approximately .05% of its total revenues of 1.52 billion for 1984.

C&C requests an order declaring it not to be an electric utility company pursuant to section 2(a)(3) of the Act. That section provides that the Commission shall by order declare a company not to be an electric utility company if it finds "such company is primarily engaged in [a nonutility business], and by reason of the small amount of electric energy sold by such company it is not necessary in the public interest or for the protection of investors or consumers that such company be considered an electric utility company for purposes of [the Act]."

The application and amendments thereto are available for public inspection through the commission's Office of Public Reference. Interesterd persons wishing to comment or request a hearing should submit their views in writing by September 19, 1985, to the Secretary, Securities and Exchange Commission, Washington, D.C. 20549, and serve a copy on the applicant at the address specified above. Proof of service (by affidavit or, in the case of an attorney-at-law, by certificate) should be filed with the request. Any request for a hearing shall identify specifically the issues of fact or law that are disputed. A person who so requests will be notified of any hearing, if ordered, and will receive a copy of any notice or order issued in this matter. After said date, the application, as filed or as it may be amended, may be authorized.

For the Commission, by the Division of Investment Management, pursuant to delegated authority.

**John Wheeler,**

*Secretary.*

[FR Doc. 85-20907 filed 8-30-85; 8:45 am]

BILLING CODE 8010-01-M

## DEPARTMENT OF TRANSPORTATION

### Federal Aviation Administration

**[FAA Order 6850.26A]**

### Federal Funding of Visual Glideslope Indicators

*Correction*

In FR Doc. 85-20364 beginning on page 34573 in the issue of Monday, August 26, 1985, make the following corrections:

1. On page 34575, in the first column, in the table entitled "Number of Pilots", the heading of the column which reads "BVASI" should read "VASI".

2. On the same page, in the second column, the third line above the table at the botton of the column should read: "PLASI—$17,695 average for 27 locations".

3. Beginning on the same page, at the bottom of the second column, in the table listing bid prices, the headings of the columns were incorrect. The corrected table is reprinted in its entirety as follows:

BILLING CODE 1505-01-M

| Location | VASI-2 | VASI-4 | PLASI | PAPI |
|---|---|---|---|---|
| Kissimmee, FL | $5,975 | | | |
| Do | 5,975 | | | |
| Ocala, FL | | | | $8,200 |
| Do | | | | 8,200 |
| Ormand Beach, FL | 7,810 | | | |
| Do | 7,810 | | | |
| St. Augustine, FL | | 5,500 | | |
| Do | 6,820 | | | |
| Leesburg, FL | | 7,070 | | |
| Do | | 7,070 | | |
| Mt. Piessant, SC | | | | 7,955 |
| Do | | | | 7,955 |
| Greenville, NC | | 9,400 | | |
| Do | | 9,400 | | |
| Lincolntown, NC | | 9,475 | | 9,475 |
| Raleigh, NC | | | | 8,700 |
| Cartersville, GA | 6,500 | | | |
| Newnan, GA | 5,650 | | | |
| Do | 5,650 | | | |
| Dalton, GA | | 9,000 | | |
| Do | | 9,000 | | |
| Punxsutawney, PA | 7,950 | | 9,110 | |
| Altoona, PA | 13,085 | | 16,000 | |
| Greenville, PA | 28,875 | | 30,000 | |
| Do | 28,875 | | 30,000 | |

| Location | VASI-2 | VASI-4 | PLASI | PAPI |
|---|---|---|---|---|
| Readsville, PA | 21,000 | | 23,500 | |
| Do | 21,000 | | 23,500 | |
| Somerset, PA | | 14,915 | 29,891 | |
| Wellsville, NY | | 22,250 | 19,500 | |
| Do | | 22,250 | 19,500 | |
| Olean, NY | 7,725 | | 13,917 | |
| Poughkeepsie, NY | 12,700 | | 21,900 | |
| Albany County, NY | | 27,640 | 17,391 | |
| Utica, NY | | 23,432 | 25,775 | |
| Port Lavaca, TX | | | | 6,000 |
| Austin, TX | 7,000 | | | |
| McKinney, TX | | | | 15,975 |
| Clarksville, ARK | 10,608 | | | |
| Sweetwater, TX | 19,945 | | | |
| McAllen, TX | 7,800 | | | |
| Conroe, TX | | 12,745 | | 10,000 |
| Harlem, MT | | | 17,725 | |
| Milbank, SD | 6,510 | | | |
| Pine Ridge, SD | 8,240 | | | |
| Do | 4,980 | | | |
| Duluth, MN | | 9,350 | 6,950 | 7,750 |
| Mora, MN | | | | 9,320 |
| Ely, MN | | 13,800 | 14,475 | 13,400 |
| Red Wing, MN | | | | 8,340 |
| Austin, MN | | | | 9,980 |
| Ulm, MN | | 6,500 | | 8,000 |
| Watford, ND | 5,170 | | | |
| Walpeton, ND | 4,800 | | 9,000 | 11,000 |
| Bowman, ND | 5,500 | | | |
| Dickenson, ND | 5,500 | | | |
| Frederick, MD | | 8,967 | 10,700 | |
| Ocean City, MD | | 13,630 | 15,158 | |
| Do | | 13,630 | 15,158 | |
| Chesterfield, VA | | 9,484 | 10,420 | |
| Blacksburg, VA | | | 25,718 | |
| Manassas, VA | 7,676 | | 10,780 | |
| Brawley, CA | 7,077 | | | |
| Do | 7,077 | | | |
| Santaynez, CA | 7,200 | | 10,000 | |
| Sedona, CA | 11,800 | | 20,000 | |
| Coolidge, AZ | 6,500 | | | |
| Do | 6,500 | | | |
| Casa Grande, AZ | 6,197 | | | |
| Do | 6,197 | | | |
| Safford, CA | 5,000 | | | |
| Do | 5,000 | | | |
| Calexico, CA | 7,564 | | | |
| Do | 7,564 | | | |
| Moses Lake, WA | | | | 18,854 |
| Pittsburg, KS | | 7,201 | | |
| Do | | 7,201 | | |
| Lebanon, MO | | | 15,000 | |
| Do | | | 15,000 | |
| Independence, IA | 5,596 | | | |
| Do | 5,596 | | | |
| Shennandoah, IA | 5,164 | | | |
| Do | 5,164 | | | |
| Hartselle, AL | 11,279 | | | |
| Do | 11,279 | | | |
| Talladega, AL | | 7,095 | | |
| Do | | 7,095 | | |
| Columbus, MS | 6,000 | | | |
| Troy, AL | | 16,000 | | |
| Fairhope, AL | | | | 6,600 |
| Do | | | | 6,600 |
| Enterprise, AL | 6,000 | | | |
| Do | 6,000 | | | |
| Eufaula, AL | 6,300 | | | |
| Do | 6,300 | | | |
| Pittsfield, MA | 3,500 | | | |
| Claremont, NH | 5,921 | | | |
| Highgate, VT | 6,350 | | | |
| Fryeburg, ME | 6,709 | | | |
| Laconia, NH | | 12,000 | | |
| Morrisville, VT | 7,500 | | | |
| Marathon, FL | | | | 17,804 |
| Do | | | | 17,804 |

BILLING CODE 1505-01-T

## Office of the Secretary

## Fitness Determination; Cross Country Aviation Service, Inc.

**AGENCY:** Department of Transportation.

**ACTION:** Notice of Commuter Air Carrier Fitness Determination—Order 85-8-81, Order to Show Cause.

**SUMMARY:** The Department of Transportation is proposing to find that Cross Country Aviation Services, Inc., is fit, willing, and able to provide commuter air service under section 419(c)(2) of the Federal Aviation Act, as amended, and that the aircraft used in this service will conform to applicable safety standards.

**RESPONSES:** All interested persons wishing to respond to the Department of Transportation's tentative fitness determination should file their responses with the Special Authorities Division, Room 6420, Department of Transportation, 400 7th Street, SW. Washington, DC 20590, and serve them on all persons listed in Attachment A to the order. Responses shall be filed no later than September 30, 1985.

**FOR FURTHER INFORMATION CONTACT:** Linda L. Lundell, Special Authorities Division, Department of Transportation, 400 7th Street, Washington, DC 20590 (202) 755-3812.

**SUPPLEMENTARY INFORMATION:** The complete text of Order 85-8-81 is available from the Documentary Services Division, Room 4107, 400 7th Street, SW., Washington, DC 20590. Persons outside the metropolitan area may send a postcard request for Order 85-8-81 to that address.

Dated: August 27, 1985.

Jeffrey N. Shane,

*Acting, Assistant Secretary for Policy and International Affairs.*

[FR Doc. 85-20958 Filed 8-30-85; 8:45 am]

BILLING CODE 4910-62-M

# Sunshine Act Meetings

Federal Register
Vol. 50, No. 170
Tuesday, September 3, 1985

This section of the FEDERAL REGISTER contains notices of meetings published under the "Government in the Sunshine Act" (Pub. L. 94-409) 5 U.S.C. 552b(e)(3).

## CONTENTS



### 1

**FEDERAL TRADE COMMISSION**

**TIME AND DATE:** 2:00 p.m., Thursday, September 5, 1985.

**PLACE:** Room 532, (open); Room 540 (closed) Federal Trade Commission Building, 6th Street and Pennsylvania Avenue, NW Washington, DC 20580.

**STATUS:** Parts of this meeting will be open to the public. The rest of the meeting will be closed to the public.

**MATTERS TO BE CONSIDERED:**

Portions Open to Public:

(1) Oral Argument in Orkin Exterminating Company, Docket No. 9176.

Portions closed to the Public:

(2) Executive Session to follow Oral Argument in Orkin Exterminating Company, Docket No. 9176.

**CONTACT PERSON FOR MORE INFORMATION:** Susan B. Ticknor, Office of Public Affairs: (202) 523–1892; Recorded Message: (202) 523–3806..

**Benjamin I. Berman,**

*Acting Secretary.*

[FR Doc. 85–21025 Filed 8–29–85; 11:52 am]

BILLING CODE 6750-01-M

### 2

**POSTAL SERVICE**

**"FEDERAL REGISTER" CITATION OF PREVIOUS ANNOUNCEMENT:** 50 FR 34961, August 28, 1985.

**PREVIOUSLY ANNOUNCED TIME AND DATE:** 8:30 a.m., Friday, September 6, 1985.

**CHANGES IN THE MEETING:** Addition of the following agenda item: "Field Management Operational Strategies".

**CONTACT PERSON FOR MORE INFORMATION:** Mr. David F. Harris, Secretary of the Board, (202) 245–3734.

**David F. Harris,**

*Secretary.*

[FR Doc. 85–21045 Filed 8–29–85; 3:03 pm]

BILLING CODE 7710-12-M

federal register

Tuesday
September 3, 1985

Part II

# Department of Transportation

## Federal Railroad Administration

**49 CFR Parts 218, 221 and 232**
**Railroad Safety: Rear End Marking Device—Passenger, Commuter and Freight Trains; Railroad Power Brakes and Drawbars; Special Safety Inquiry, Railroad Power Brakes; Proposed Rules**

**DEPARTMENT OF TRANSPORTATION**

**Federal Railroad Administration**

**49 CFR Parts 218 and 221**

**[Docket No. RSRM-2, Notice 1]**

## Rear End Marking Device; Passenger, Commuter and Freight Trains

**AGENCY:** Federal Railroad Administration (FRA), Transportation.

**ACTION:** Notice of proposed rulemaking (NPRM).

**SUMMARY:** FRA proposes to amend 49 CFR Part 221 to reflect changes in railroad operations and technological developments that have occurred since adoption of this rule. The proposed changes would permit railroads greater flexibility in selecting the personnel who perform the required inspection of rear end marking devices and would accommodate recently developed telemetry devices that provide an electronic check on the marker's condition and display that information on a monitor located in the locomotive cab. In addition, FRA proposes to adopt new procedures in Part 221 to protect non-train crew personnel who perform the inspection and to make a corresponding amendment to 49 CFR Part 218. FRA proposes this action in response to technological change and in recognition of the many requests it has received for waivers of compliance that seek expansion of the categories of personnel permitted to conduct the required inspections.

**DATES:** (1) A public hearing will begin at 10:00 a.m. on October 23, 1985.

(2) Prepared statements to be made at the hearing should be submitted to the Docket Clerk at least seven days before the hearing date.

(3) Persons desiring to participate in the hearing should notify the Docket Clerk at least seven days before the hearing date.

(4) Written comments must be received not later than October 31, 1985. Comments received after that date will be considered to the extent possible without incurring additional expense or delay.

**ADDRESSES:** (1) Hearing location. Room 7200 of the Nassif Building located at 400 Seventh Street SW., Washington, D.C.

(2) Written comments should be submitted to the Docket Clerk, Office of Chief Counsel, FRA, 400 Seventh Street, SW., Washington, D.C. 20590. Persons desiring to be notified that their written comments have been received by FRA shall submit a stamped, self-addressed postcard with their comments.

The Docket Clerk will indicate on the postcard the date on which the comments were received and will return the card to the addressee. Written comments will be available for examination, both before and after the closing date for comments, during regular business hours in Room 8201 of the Nassif Building at the above address.

**FOR FURTHER INFORMATION CONTACT:** Philip Olekszyk, Deputy Associate Administrator for Safety, FRA, Washington, D.C. 20590. Telephone: 202-426-0897.

**SUPPLEMENTARY INFORMATION:**

### Background

Section 5(b) of the Federal Railroad safety Authorization Act of 1976 (Pub. L. 94-348) required the issuance of necessary rules to require that the rear car of passenger, communter, and freight trains be equipped with highly visible markers within 180 days of its enactment. In response, FRA promulgated 49 CFR Part 221 on January 11, 1977 (42 FR 2321). In the development of that rule within the statutory period, the primary issue under discussion was whether a lighted or a retroreflective device was appropriate for freight trains. The intense concern over that issue resulted in litigation (*Association of American Railroads* v. *Adams*, 485 F. Supp. 1087 (D.C. Cir. 1978)) and distracted the commenters from the problems that were presented by other aspects of the rule.

In the eight years that have elapsed since the adoption of this rule, technological developments, operational changes and minor deficiences in the initial rule have combined to convince FRA that some regulatory changes are needed. The changes being proposed by FRA in this notice would (i) clarify the regulatory language concerning the equipping and inspection provisions; (ii) revise the inspection requirement to permit it to be either a visual observation or a radio telemetry vertification; (iii) permit expansion of the inspection force authorized to conduct the visual observation if they are given adequate training; and (iv) permit the use of a new procedure to protect this expanded inspection force.

### Regulatory Clarification

FRA proposes to amend the regulatory language to reflect changes in industry practices since adoption of the original rule. In addition, FRA's enforcement experience over the years has shown that some improvement in the regulatory language would be helpful.

For example, FRA's implicit reliance on industry practices, prevalent at the time, provided the context for its decision not to impose an explicit requirement that an inspection be made to verify the presence and operational readiness of rear marker devices at initial terminals. At that time, virtually all trains were being operated with a caboose as the last car in the train. Many of these cabooses were equipped with electrical power and, as FRA assumed, the railroads merely outfitted these cars with a permanently installed rear marker device. Those cabooses not equipped with electrical power generally had brackets installed for mounting portable devices. FRA implicitly decided to rely on the crew occupying the caboose to check the device when boarding their train at the initial terminal. Since time is not normally of the essence when boarding at the initial terminal and since their own personal safety was at stake, FRA believed the same strong personal safety motivation that had fueled the drive for legislation would promote matter-of-course inspections.

FRA's approach to initial terminal inspections contrasts sharply with the approach taken in dealing with the enroute inspections after that same train had departed its initial terminal. In dealing with enroute inspections, FRA explicitly required that the inspection be made and limited the inspection force to train crew members. The inconsistency in FRA's approach was not commented on in the process of adopting the initial rule, and FRA has struggled with this regulatory discrepancy ever since the rule's adoption.

Over the years, FRA has also learned that the draftsmanship of this rule does not permit simple and effective enforcement. For instance, FRA inspectors have observed trains departing initial terminals without a visible marker when the inspectors are aware that the departing trains will likely encounter either bad weather or darkness during their trips. Although the inspectors have believed that such trains are not equipped and thus cannot display the marker if necessary, they are unable to take effective action without following that train to observe it until those circumstances arise. Subsequent observation is necessary to establish a failure-to-equip violation since, under the existing rule, FRA must demonstrate that the device was not stored inside the caboose where it was not visible to the inspector. The difficulty inherent in checking inside a caboose (the most

likely storage place) when observing an already moving train is obvious, and as a result, FRA's enforcement effort has focused on failure-to-display (during darkness or periods of reduced visibility) rather than failure-to-equip violations

**Accommodating New Technology**

FRA also proposes to permit the use of radio telemetry equipment as an alternative to visual observations. Products have recently come on the market that will monitor the condition of the rear end marker device and communicate that information through radio telemetry to a receiver located in the cab of a train's controlling locomotive. The degree of information and the sophistication of the monitoring varies, but some of these units are designed to check all of the functional elements of the marker device, including the filament of the bulb. Designs such as this, which guard against a wide variety of potential failure modes for the device, represent a significant improvement of the devices and provide an effective alternative inspection method.

FRA is proposing to permit the introduction of this new technology. Since this regulation already requires that railroads obtain FRA approval before using a marker device, FRA is already poised to review the design of new devices on a case-by-case basis. This review process will permit FRA to have a detailed understanding of any telemetry augmentation of the marker device before sanctioning its use as a substitute for visual inspection.

**Increasing the Inspection Force**

The third objective of these proposed changes is to permit additional employees to perform the visual marker inspection. Section 221.15(d) of the rule requires that when a train crew assumes responsibility for their train the device must be inspected by member of that train crew to assure that the marker device will perform its intended function during periods of darkness or adverse weather conditions.

Although one commenter suggested that FRA was being unduly restrictive in permitting only train crews to perform the inspection, FRA concluded that placing inspection responsibility on these individuals was appropriate. With the advent of cabooseless freight trains, concern over this constraint has arisen again. Several individual railroads, among them the Seaboard System, Chessie System, Burlington Northern, Consolidated Rail Corporation, and Atchison Topeka and Santa Fe Railway have requested that FRA permit them to use a variety of personnel, including mechanical department employees and supervisory personnel, to perform the needed inspection. As pointed out by the railroads and confirmed by FRA field inspections, no unusual skill or training is needed to perform the inspection and there is no discernible safety rationale for continuing this constraint in the face of changed operational practices. Indeed, by implicitly proscribing the use of all personnel but train crew members, the rule may in fact discourage more thorough examinations of trains.

After reviewing the individual railroad requests for waivers of compliance to permit noncrew members to perform the inspection, FRA believes that the rule as presently written is unduly restrictive and poses an economic burden that is not justified by a need to provide for employee safety. Since the problem affects all railroads, FRA is acting to improve the situation on an industry-wide basis rather than in the piecemeal approach suggested by the individual railroads.

When a railroad selects noncrew members to perform this inspection, however, FRA believes the railroad must determine that such personnel are qualified to accomplish this task. Even though minimal skill and ability are involved in performing the simple task of repositioning an activation switch or covering a photoelectric cell to determine whether the marker will function, there is a need to know that the individual performing the task shares the crew members' awareness of the safety function of this device, knows the proper safety procedures to follow when in close proximity to rolling equipment, and understands the proper procedure to follow if a failed device is found. In addition, the person needs to have effective communications with the new train crew so that personal notification can be accomplished. If a railroad chooses to use radio communications for this purpose, these personnel must be properly schooled in the use of radios.

**Alternative Methods of Protection: "Blue Signal Rule"**

The task of covering a photoelectric cell or repositioning an activation switch will usually require people to position themselves behind the last car of a train and within the clearance lines for that car. A person in that position is exposed to risk of injury from the unexpected movement of that car. For that reason, FRA has adopted rules requiring "blue signal" protection (49 CFR Part 218) for certain employees performing that task. In essence, these rules require that blue lights or blue flags be displayed to warn people that the equipment being protected must not be moved.

In adopting its blue signal regulation, FRA generally followed preexisting industry practice. The FRA rule also identified some personnel and tasks for which the requirement to provide blue signal protection was unnecessary. For example, the industry rule was intended to alert train and engine crews to the fact that a non crew member was in a position that exposed that worker to serious danger if the protected equipment was moved. The FRA rule, like the industry rule, recognized that crew members work as a unit and know one another's whereabouts. As a consequence, the industry rule exempted members of the train crew from blue signal protection and FRA adopted the same exception. FRA also identified certain discrete tasks which, though performed by other personnel, provide minimal exposure to the danger of moving equipment. Exceptions for those tasks were also incorporated and experience has shown these decisions to have been well taken.

The changes in the rear marker inspection requirements made necessary by the operation of cabooseless trains have prompted FRA to reevaluate the present blue signal requirements as well. Our analysis of the crew change inspection of rear markers reveals that, if only certain discrete tasks are performed during a marker inspection, the level of danger is substantially minimized, and if alternative protective measures are employed, there is no useful purpose in mandating blue signal protection. In attempting to reduce the risk of unanticipated movement, two primary energy sources must be considered: other trains and the locomotives of the train being inspected. The first involves the possibility that another train could strike the train being inspected and cause the standing train to move. When a train is occupying the main track, it is protected from impact by other trains because access to main track is limited by the railroad's operating rules. Under those rules, the potentially conflicting movement can occupy that main track only when authorized by timetable, train order, or signal indication. Therefore, when the train being inspected is positioned on a main track, the risk that it will move as a result of being struck by other rolling equipment, is remote.

The second potential energy source that could cause the unanticipated movement of the train being inspected is that train itself. This could occur because someone operated either the throttle or the brake controls for that

train. The risk of movement from this energy source can be eliminated when a crew member is positioned in the locomotive cab compartment of the controlling locomotive to control and thus prevent operation of both the throttle and brake controls. FRA believes that the person occupying the cab compartment of the controlling locomotive of the train must have an effective communications link to the inspector, since it is this person who is assuring the inspector that the train itself is secure against movement and will remain that way until the inspection has been completed. A system that incorporates these critical elements would, in FRA's judgment, functionally provide this inspector with the same status and protections as a member of the train crew and, for the same reasons, so minimize the risk of injury that it would be appropriate to authorize the inspection to be conducted without blue signal protection.

**Section-By-Section Analysis**

*Section 221.5*

FRA proposes to add a new definition to this section. This new definition reflects the expansion of the inspection force that FRA is sanctioning under proposed § 221.15 and the new procedures that FRA is sanctioning under § 221.16. FRA proposes to define the expanded inspection force as qualified only when they have been given adequate training concerning the task they are being asked to perform. As noted earlier, the degree of instruction needed will vary according to the type of experience the worker has had, but since new procedures are involved here, FRA believes that some training must be given to all non-train crew personnel before such a person can legally perform this task.

*Section 221.13*

FRA proposes to reword both paragraphs (a) and (b) to eliminate the inartful draftsmanship of the existing provision. The reworded provision would clearly set forth the existing requirement that each train be equipped; that the device be visible on the trailing end of the last car; and that the device be illuminated during darkness or periods of restricted visibility.

*Section 221.14*

FRA proposes to transfer the provisions that are currently contained in § 221.15 to this newly designated section. FRA is also proposing to delete from the repositioned section the requirement in paragraph (d) for train crew inspection at enroute crew change points. The requirements contained in paragraph (d) would be rewritten and would appear as § 221.15 under this proposal.

*Section 221.15*

FRA proposes to retain the requirement that rear markers be inspected at enroute crew change locations; to make explicit the requirement for an initial terminal inspection of the device; to accommodate possible telemetry inspections; and to permit the railroads to select individuals other than train crew members to conduct the inspection. FRA would require that the railroads only use personnel that the railroad has determined are qualified to perform this inspection in terms of their familiarity with the equipment, the inspection task, and the appropriate procedures to be followed to obtain the needed levels of personal safety when in such proximity to rolling equipment. In FRA's judgment, this would necessitate some training for all affected railroad employees and may require equipping some personnel with a communications capability that they do not currently possess.

*Section 221.16*

FRA is proposing to add an entirely new provision to the rule to allow railroads to conduct the required inspection in an expeditious fashion. As noted earlier, FRA believes that this new alternate inspection method will not have any adverse safety implications since the inspector will be receiving the same level of protection historically afforded to train crews; and it will reduce the economic burden for railroads by affording them some additional flexibility. This proposal is limited to "main track" (defined in § 221.5(d)), since only there do the operating rules serve to prevent other trains from occupying the track where the person needing protection will be stationed. This procedure would usually demand that both the locomotive engineer and the inspector be equipped with operating radios. The locomotive would have to be occupied by the locomotive engineer during the inspection to preclude movement before the task is completed. Although FRA considers this inspector to be functionally a member of the train crew, this proposal would not sanction any activity beyond either covering a photoelectric cell or repositioning the marker's activation switch. Under FRA's proposal, if a railroad wants to have battery readings taken, devices repaired, replaced, repositioned or otherwise given additional attention, or if other work is to be performed that is not related to the marker device, then the railroad must fully comply with the blue signal provisions of Part 218.

*Section 218.5*

FRA is proposing to make a corresponding change to the blue signal rules contained in Part 218. This proposed change would alter the language of the footnote to the definitions section of Part 218 to reflect the existence and relevance of this new inspection procedure. In adopting the revisions to this regulation that occured in 1979, FRA explicitly set forth in the footnote to § 218.5(a) the very narrow tasks that could be performed without providing a workman with protection. Since the task being performed during the marker inspection is primarily an operational test of the device and/or a visual check, FRA is proposing to revise the portion of the footnote relating to "testing" to reflect this new procedure.

**Regulatory Impact**

This NPRM has been evaluated in accordance with existing regulatory policies. It is neither a "major" proposed rule under Executive Order 12291 nor a "significant" proposed rule as defined under DOT policies and procedures.

The rule, if adopted, would not increase the economic burden of the existing regulation and has the potential for reducing the cost of compliance since it would provide the railroads with alternative means of complying with an existing rule. Although FRA is constrained in its analysis by the absence of well defined industry-wide economic data, FRA has prepared and placed in the rulemaking docket a draft economic analysis addressing the impact of the proposed rule. It can be inspected or copied at Room 8201, 400 Seventh Street SW., Washington, D.C. Copies can also be obtained from the Docket Clerk, FRA at the same address.

FRA's economic evaluation identifies total estimated benefits from avoidance of train delays to be $9,802,000 per year. The total first-year costs, attributable to the purchase and installation of telemetry devices, that can be associated with the proposed rule changes are estimated at $1,370,000. These amounts are annual averages from a 20 year forecast that uses a 10 percent discount rate. The benefit to cost ratio for the entire forecast period would be 7 to 1. Although this cost benefit ratio is conservative for a number of reasons, it necessarily simplifies the multiple variables that each railroad will have to consider in analyzing the economic and safety

benefits to be realized in the context of its specific operating environment when responding to this rule change. FRA specifically requests that commenters provide information on the question of the economic impact of this NPRM.

Since the rear marker regulation only applies to railroads and exempts from compliance small railroads that only operate one train at a time, this proposed rule would have no economic impact on those railroads. To the degree that any small railroad must comply with this regulation, this proposed rule would not have an adverse economic impact since it permits them greater discretion. Based in the facts set forth in this NPRM, it is certified that this rule will not have a significant economic impact on a substantial number of small entities under the provisions of the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*). The information collection requirements in this proposed rule are being submitted to the Office of Management and Budget under the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 *et seq.*).

### Environmental Impact

On June 16, 1980, FRA published (45 FR 40850) revised procedures for ensuring full consideration of the environmental impacts of FRA actions as required by the National Environmental Policy Act (42 U.S.C. 4321 *et seq.*), other environmental statutes, Executive Orders, and DOT Order 5610.1C. These FRA procedures require that an "environmental assessment" be performed prior to all major FRA actions.

The FRA environmental procedures also contain a provision that enumerates seven criteria which, if met, demonstrate that a non-categorically exempt action is not a "major" action for environmental purposes. These criteria involve diverse factors, including the availability of adequate relocation housing; the possible inconsistency of the action with Federal, State or local law; the possible adverse impact on natural, cultural, recreational, or scenic environments; the use of properties covered by section 4(f) of the DOT Act; and the possible increase in traffic congestion. This proposed rule meets the seven criteria that establish an action as non-major.

### Public Participation

Interested persons are invited to participate in this proceeding by submitting written data, views, or comments and this proposal may be changed in light of the comments received. Communications should identify the regulatory docket number and notice number and must be submitted in triplicate to the Docket Clerk, Office of Chief Counsel, Federal Railroad Administration, 400 Seventh Street SW., Washington, D.C. 20590. Persons desiring that receipt of their communications be acknowledged should attach a stamped, pre-addressed postcard to the first page of their communication. Communications received before October 31, 1985, will be considered before final action is taken on the proposed rule. All comments received will be available for examination by interested persons at any time during regular business hours in Room 8201, Nassif Building, 400 Seventh Street SW., Washington, D.C. 20590.

In addition FRA has scheduled a public hearing to be held on October 23, 1985, in Washington, D.C. This hearing is scheduled to begin at 10:00 a.m. in Room 7200 of the Nassif Building located at 400 Seventh Street SW., Washington, D.C. Persons desiring to participate in the hearing should notify the Docket Clerk at least seven days before the hearing and indicate the amount of time they will need to present their views. Prepared statements also should be submitted to the Docket Clerk at least seven days before the hearing date.

### List of Subjects

*49 CFR Part 218*

Railroad safety, Railroad operating rules.

*49 CFR Part 221*

Railroad safety, Rear end marking devices.

In consideration of the foregoing, FRA proposes to amend Part 221 and Part 218, Title 49, Code of Federal Regulations, as set forth below:

1. The authority citation for Parts 218 and 221 continues to read as follows:

**Authority:** Sec. 202, 84 Stat. 971 45 U.S.C. 431; § 1.49(m) of the Regulations of the Secretary of Transportation (49 CFR 1.49(m).

## PART 221—[AMENDED]

1. Section 221.5 is amended by adding a new paragraph (i) to read as follows:

**§ 221.5 Definitions.**

* * * * *

(i) "Qualified person" means any person who has the skill to perform the task and has received adequate instruction.

2. Section 221.13 is amended by revising paragraphs (a) and (b) to read as follows:

**§ 221.13 Marking device display.**

(a) Each train to which this part applies that occupies or operates on main track shall be equipped with and display a marking device prescribed by this part on the trailing end of the rear car of that train.

(b) The marking devices prescribed by this subpart shall be illuminated continuously during the hours between one hour before sunset and one hour after sunrise, and during all other hours when weather conditions so restrict visibility that the end silhouette of a standard box car cannot be seen from ½ mile on tangent track by a person having 20/20 corrected vision.

* * * * *

3. Section 221.15 is redesignated as § 221.14 and is revised to read as follows:

**§ 221.14 Marking Devices.**

(a) Passenger, commuter and freight trains shall be equipped with at least one marking device which the Administrator approves, according to the procedures included in Appendix A of this part, as having an intensity of not less than 100 candela nor more than 1000 candela for flashing lights) as measured at the center of the beam with:

(1) A horizontal beam with a minimum arc width of fifteen (15) degrees each side of the vertical center line, and a vertical beam with a minimum arc width of five (5) degrees each side of the horizontal center line as defined in terms of the 50 candela intensity points;

(2) A color defined by the red-orange-amber color range; and

(3) If a flashing light is used, a flash rate of not less than once every 1.3 seconds nor more than once every .7 seconds.

(b) Marking devices used on passenger and commuter trains in compliance with paragraph (a) of this section shall be lighted under the conditions prescribed in § 221.13(b).

(c) When a locomotive is operated singly, or at the rear of a train, highly visible marking devices may be provided by the use of:

(1) At least one marking device which complies with paragraph (a) of this section; or

(2) At least one illuminated red or amber classification light on the rear of the locomotive, provided it complies with paragraph (a) of this section; or

(3) The rear headlight of the locomotive illuminated on low beam.

4. Add a new § 221.15 to read as follows:

**§ 221.15 Marking Device Inspection.**

(a) Each marking device displayed in compliance with this part shall be tested at a train's initial terminal and at each

crew change point to assure that the device is in proper operating condition.

(b) This test shall be accomplished by visually observing the condition of the device and determining that the device will function, by either (1) repositioning the activation switch or (2) covering the photoelectric cell.

(c) This test shall be conducted either by the train crew or some other qualified person, provided that, if a non-train crew member performs the test, the qualified person shall personally communicate the test findings to the locomotive engineer of the new train crew.

(d) When equipped with an approved radio telemetry capability, a marker displayed in accordance with this part may be tested by activating the monitoring function of the device and observing the readout information displayed in the cab of the controlling locomotive in lieu of conducting a visual observation.

5. Add a new § 221.16 to read as follows:

**§ 221.16 Inspection Procedure.**

(a) Prior to operating the activation switch or covering the photoelectric cell when conducting this test, a non-train crew person shall determine that he is being protected against the unexpected movement of the train either under the procedures established in Part 218 of this chapter or under the provisions of paragraph (b) of this section.

(b) In order to establish the alternative means of protection under this section (1) the train to be inspected shall be standing on a main track; (2) the inspection task shall be limited to ascertaining that the marker is in proper operating condition; and (3) prior to performing the inspection procedure, the inspector shall personally contact the locomotive engineer and be advised by that engineer that the engineer is occupying the cab of the controlling locomotive and that the train is and will remain secure against movement until the inspector's device activation task has been completed.

## PART 218—[AMENDED]

6. In section 218.5, the footnote to paragraph (a) is revised to read as follows:

**§ 218.5 Definitions.**

(a) * * *

Note.—"Servicing" does not include supplying cabooses, locomotives, or passenger cars with items such as ice, drinking water, tools, sanitary supplies, stationery, or flagging equipment.

"Testing" does not include (i) visual observations made by an employee positioned on or alongside a caboose, locomotive, or passenger car; or (ii) marker inspections made in accordance with the provisions of § 221.16(b) of this chapter.

Issued in Washington, DC on August 26, 1985.

John H. Riley,

*Administrator.*

[FR Doc. 85-20742 Filed 8-30-85; 8:45 am]

BILLING CODE 4910-06-M

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## 49 CFR Part 232

**[Docket No. PB-7, Notice No. 1]**

## Railroad Power Brakes and Drawbars

**AGENCY:** Federal Railroad Administration (FRA), Department of Transportation (DOT).

**ACTION:** Notice of proposed rulemaking (NPRM).

**SUMMARY:** This notice proposes to amend FRA's power brake rules to permit use of a telemetry device that provides, in the cab of the controlling locomotive, a continuous readout of the brake pipe pressure at the rear car of a train, as an alternative to reliance on a gauge at the end of the train and visual observation of the application and release of the brakes on the rear car during intermediate terminal air brake tests. This action is in response to a petition for rulemaking submitted by the Association of American Railroads (AAR).

**DATES:** (1) *Written Comments*: Written comments must be receive before October 31, 1985. Written comments received after that date will be considered to the extent possible without incurring additional expense or delay.

(2) *Public Hearing*: A public hearing will be held at 10:00 a.m. on October 24, 1985. Any person who desires to make an oral statement at the hearing should notify the Docket Clerk before October 17, 1985 by phone or by mail.

**ADDRESSES:** (1) Written Comments: Written comments should identify the docket number and the notice number and must be submitted in triplicate to the Docket Clerk, Office of the Chief Counsel, Federal Railroad Administration, 400 Seventh Street SW, Washington, DC 20590. Persons desiring to be notified that their written comments have been received by FRA shall submit a stamped, self-addressed postcard with their comments. The Docket Clerk will indicate on the postcard the date on which the comments were received and will return the card to the addressee. Written comments will be available for examination, both before and after the closing date for written comments, during regular business hours in room 8201 of the Nassif Building at the above address.

(2) Public Hearing: A public hearing will be held in room 7200 of the Nassif Building. Persons desiring to make oral statements at the hearing should notify the Docket Clerk by telephone (202-426-8325) or by writing to: Docket Clerk, Office of Chief Counsel, Federal Railroad Administration, at the above address.

**FOR FURTHER INFORMATION CONTACT:**

*Principal Program Person*: Philip Olekszyk, Office of Safety, Federal Railroad Administration, Washington, DC 20590. Telephone 202-426-0897

*Principal Attorney*: Michael E. Chase, Office of Chief Counsel, Federal Railroad Administration, Wasington, DC 20590. Telephone 202-426-8285.

**SUPPLEMENTARY INFORMATION:**

### Background

On June 5, 1984, FRA conducted a Safety Inquiry hearing to explore the safety implications inherent in sanctioning the use of radio telemetry devices, in lieu of gauge and visual observation, to convey information about the functioning of a train's air brake system. That hearing was partially responsive to an earlier AAR request that FRA amend its regulations pertaining to railroad power brakes (49 CFR Part 232) and most specifically the provisions in § 232.13, "Road Train and Intermediate Train Air Brake Tests."

The changes AAR is seeking are designed to permit the optional use of a device at the rear of a train in lieu of visual inspection of the rear of the train for compliance with certain test procedures in § 232.13. The device would monitor the brake pipe pressure at the rear of the train and convey that information to the cab of the locomotive controlling the train. Thus, where the current rule requires a gauge at the rear of the train to ascertain brake pipe pressure, the device could be used instead. Similarly, where the current rule requires a visual determination of the application and release of the brakes on the rear car, the device could be used instead to read the decrease and increase in brake pipe pressure resulting from a train crew member's applying and releasing the brakes by operating the brake valve on the locomotive. This decrease and increase could be used to determine the application and release of the brakes on the rear car.

**Background on the Train Air Brake System and the Individual Car Air Brake System**

The train air brake system is complex and sensitive. A simplified and summarized understanding of its operation is ueful in analyzing the impact of the proposed regulatory changes. In essence, the train air brake system has three major parts—(1) a signal sender, (2) a signal relayer, and (3) a signal receiver/responder.

The brake valve on the locomotive is the signal sender. Operation of the valve permits air to be pumped into or released from the brake pipe. The pressure change resulting from the additional or reduced air supply in the brake pipe is the "signal."

The brake pipe, also known as the train air line, is the "signal relayer". It is the continuous air line running from the front of the train to the rear of the train. The continuity of the air line from car-to-car is accomplished by means of flexible air hoses. The brake pipe is closed (sealed) at the rear of the train and pressurized so that, apart from air leakage in the system, changes in the brake pipe pressure are made through operation of the brake valve on the locomotive.

When the engineer on a locomotive "sets the brakes," air is released from the brake pipe through the locomotive brake valve. This release of air reduces the pressure of the brake pipe (the signal), beginning at the front of the train. The pressure reduction moves down the brake pipe (propagates) to the rear of the train. Thus, the signal (pressure reduction) is relayed by the brake pipe to the entire train. Similarly, when the brakes are released, the locomotive brake valve is positioned so that air is pumped into the brake pipe, sending a pressure increase through the brake pipe. A pressure reduction in the brake pipe rather than a pressure increase initiates a brake application. Thus, the train air brake system is said to be "failsafe," *i.e.*, if an air hose bursts, the resulting loss of air pressure in the brake pipe will initiate a brake application.

The third major part of the train air brake system is the "signal receiver/responder"; valves located on each car, which receive and interpret the changes in the brake pipe pressure. These signal receiving valves initiate the application or release of the brakes on each individual car. The degree of braking effort is determined by the degree of the brake pipe pressure drop, generally described as a partial service reduction, a full service reduction, or an emergency application.

The individual car air brake system is also complex. Although specific features vary from car to car, the individual car air brake system has five major components: (1) A signal receiving/responding valve (actually a series of valves); (2) air reservoirs (auxiliary and emergency); (3) brake cylinder(s); (4) brake rigging; and (5) brake beam and shoes. When a brake application signal is received by the signal receiving valve, the valve causes air to be transferred from the air reservoir(s) to the brake cylinder. (Whether air is transferred from both reservoirs or only the auxiliary reservoir is a function of the degree of the brake pipe pressure reduction.) The pressure of the transferred air causes the piston in the brake cylinder to move. The piston pushes the brake rigging (a series of rods and levers designed to increase the braking ratio), which moves the brake beam. The brake beam pushes the brake shoe against the wheel, which causes the braking action. (Truck mounted brakes and certain other types of brakes operate somewhat differently, but the differences are not pertinent to this analysis or the proposed changes to the rule.)

Although a pressure reduction in the brake pipe signals a brake application, the actual application of the brakes to stop the train requires stored air under pressure from the air reservoirs. The air reservoirs on each of the cars in a train are supplied this air by the brake pipe, which is pressurized, in a process called "charging the train." The train is charged before it is tested, and about six minutes are required to charge a single car (assuming the car air reservoirs are empty and the air pressure is being generated by an air compressor on a locomotive). Since numerous cars can be charged at the same time, however, a fifty-car train can be charged in approximately twenty minutes.

There is a limit to the number of brake applications that can be made in a short period of time, because each application reduces the air in the reservoirs, and some time must elapse before the reservoirs are recharged. Thus, several brake applications within a short time interval can sharply reduce the braking effectiveness of the system.

There was extensive discussion during the June hearing of the safety impact of the requested changes and the relationship of test procedures in § 232.13 to the operation of the train air brake system. Based on that discussion, other information obtained at the hearing, and operational data gathered during six, FRA-sanctioned test programs, FRA believes that the AAR's requested changes, with some modification, would provide a level of safety, in terms of the integrity of the air brake system, at least equivalent to that provided by the current rules.

**Train Air Brake Tests**

The initial terminal test is the cornerstone of air brake test procedures for road trains. It is a comprehensive test designed to insure that the train air brake system and each individual car's air brake system are operating properly. The test procedures in § 232.13 are "essentially derivative and are designed to deal with specific events that potentially undermine the previously determined effectiveness of the train air brake system." 47 FR 7285. These "events" include changing locomotives, picking up cars, and setting out cars.

In general, the requirement in various subsections of § 232.13 to determine that the brakes on the rear car apply and release serves the purpose of assuring brake continuity, *i.e.*, that no angle cock between the locomotive and the rear car has been left closed as a result of changes in the train consist. The rear car portion of the intermediate train air brake test is not intended to be a recheck of an individual car that was previously examined at the location where the train was made up. A device that accurately and continuously monitors the brake pipe pressure on the rear car, and continuously relays that information to the cab of the controlling locomotive, provides a reliable indication of the brake pipe continuity. Similarly, where there is a requirement in § 232.13 to charge the brake system to a given pressure "as indicated at rear of train," it makes no difference to safety whether the crew member is reading the brake pipe pressure while physically located at the rear of the train or while located in the cab of the locomotive. The important factor for compliance with the requirement is whether the gauge or device provides an accurate measurement of the pressure at the rear of the train.

**Section-By-Section Analysis**

*Section 232.13(b)*

FRA proposes to permit use of a "device" in addition to a "gauge" to ascertain that brake pipe pressure is being restored at the rear of the train. The performance specifications of the device would be included in a proposed new paragraph (g).

*Section 232.13(c)*

FRA proposes to permit use of a "device" to determine that brake pipe pressure has been charged to the prescribed level. FRA also proposes to

permit the device to be used to ascertain that the rear car brake pipe pressure is being reduced, as an alternative to a visual determination that the rear car brakes have applied. Finally, FRA proposed to permit the device to be used to ascertain that the rear car brake pipe pressure is being restored, as an alternative to a visual determination that the rear car brakes have released. Reliance on changes in rear car brake pipe pressure to determine the application and release of the brakes on the rear car appears to be reasonable since the valve on each individual car is designed to respond to such changes in pressure.

*Section 232.13(d)(1)*

As in § 232.13(c), FRA proposes to permit use of a device to determine that the brake pipe at the rear of the train is charged to the specified level, and to ascertain that the rear car pressure is being reduced and restored in lieu of determining visually that rear car brakes have applied and released. In addition, FRA proposes to incorporate the procedure authorized in a recent FRA technical bulletin that permits a single 20-pound brake pipe reduction in lieu of a 15-pound reduction followed by increasing the reduction to full service.

*Section 232.13(d)(2)*

FRA proposes to permit use of a gauge or device to determine that the rear car brake pipe pressure is being reduced and restored, as an alternative to a visual determination that the brakes on the rear car apply and release. To avoid any confusion about the proper test procedure, FRA also would propose to spell out the requirement to charge the train before the brake pipe pressure is reduced.

*Section 232.13(g)*

FRA proposes to add a new paragraph (g) describing the performance standards for a device that may be used to comply with the test procedures in § 232.13. The device must be capable of accurately determining the brake pipe pressure on the rear car on a continuous basis and must convey that continuous quantitative value in not more than one pound increments to the cab of the controlling locomotive. The display in the cab must be readily visible in daylight and at night from the engineer's normal operating position. Given this approach, FRA would consider the cab display to be a "brake gauge" subject to the provisions of § 229.53 of the Locomotive Safety Standards (49 CFR Part 229). Since that display will, under normal circumstances, only mimic the information communicated from the device at the end of the train, FRA would consider that device to be an integral part of the locomotive brake gauge and, therefore, also subject to the provisions of §§ 229.25 and 229.53. Although FRA has not previously considered a detached or detachable device part of a locomotive, these new monitoring devices, which function as an appurtenance to that locomotive, appear to warrant this treatment. By treating the devices as detached or detachable air gauges, FRA would have an effective way to remedy any accuracy or reliability problems.

In addition to the performance standards in proposed § 232.13(g), FRA is requesting comments on the need for other performance criteria. In particular, FRA is interested in comments addressing appropriate battery capacity requirements and methods for ensuring the uniqueness of the signal of each individual rear car device.

FRA is closely monitoring the accuracy and reliabilty of the initial units that have been placed in service. This involves a variety of devices in the sanctioned test programs, and FRA may revise this proposal on the basis of subsequent test data. In part, the extended comment period being provided in this proceeding is designed to permit the collection and analysis of the information generated by the test programs.

*Section 232.13(h)*

FRA proposes to add a new paragraph (h) requiring that the accuracy of the device be checked at the initial terminal air brake test. The accuracy will be determined by cross checking the rear car brake pipe pressure.

In addition to the proposed changes to § 232.13 noted above, other possible editorial changes are reflected in the contemplated proposed rule. These potential changes are not intended to alter any substantive requirements.

The possible course of action being proposed in this NPRM is not the only way to address the topic of telemetry devices. FRA seeks the ideas and suggestions of all parties about alternative approaches to this topic. In making such suggestions FRA asks that commenters provide as much detail as possible concerning their ideas, including the comparative advantages or disadvantages of their recommended course of action.

**Regulatory Impact**

This NPRM has been evaluated in accordance with existing regulatory policies. It is neither a "major" rule as defined under Executive Order 12291 nor a "significant" rule under DOT's policies and procedures.

The rule, if adopted, would not increase the economic burden of the existing regulation since it does not propose any new mandatory requirement. The proposed alternative method of compliance with the existing requirement will have a positive economic impact by permitting carriers to reduce delays associated with manual power brake inspections at intermediate points. Although FRA is constrained in its analysis by the absence of well defined industry-wide economic data, FRA has prepared and placed in the docket a draft economic analysis addressing the impact of the proposed rule. It can be inspected or copied at Room 8201, 400 Seventh Street SW., Washington, DC. Copies can also be obtained from the Docket Clerk at the same address. FRA's economic evaluation identifies total estimated benefits from avoidance of train delays to be $11,135,000 per year. The total first year costs, attributable to the purchase and installation of telemetry devices, are estimated at $1,370,000. These amounts are annual averages from a twenty year forecast that uses a 10 percent discount rate. The benefit to cost ratio for the entire forecast period would be 8 to 1. Although this cost benefit ratio is conservative for a number of reasons, FRA specifically requests that commenters provide information on the economic impact of this NPRM. Accordingly, it is certified that the contemplated rule, if promulgated, would not have a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*). It does not constitute a major Federal action significantly affecting the quality of the human environment and, therefore, an environmental impact statement is not required.

**Public Participation**

Interested persons are invited to participate in this proceeding by submitting written data, views, or comments. Communications should identify the regulatory docket number and notice number and must be submitted in triplicate to the Docket Clerk, Office of Chief Counsel, Federal Railroad Administration, 400 Seventh Street SW., Washington, DC 20590. Persons desiring that receipt of their communications be acknowledged should attach a stamped pre-addressed postcard to the first page of their communication. Communications received before October 31, 1985 will be

considered before final action is taken on the proposed rule; comments filed after this date will be considered to the extent practicable.

All comments received will be available for examination by interested persons at any time during regular business hours in Room 8201, Nassif Building, 400 Seventh Street SW., Washington, DC 20590.

In addition, FRA will hold a public hearing on this proposal in Washington, DC. The public hearing will be held beginning at 10:00 a.m. on October 24, 1985 in room 7200 of the Nassif Building, located at 400 Seventh Street SW, Washington, DC.

**List of Subjects in 49 CFR Part 232**

Railroad safety.

**The Proposed Rule**

In consideration of the foregoing, FRA proposes to amend § 232.13 of Part 232, Title 49, Code of Federal Regulations, as follows:

1. The authority citation for Part 232 continues to read as follows:

**Authority:** 72 Stat. 86, 45 U.S.C. 9; sec. 6(e), (f), 80 Stat. 939, 49 U.S.C. 1655; and § 1.49(c) of the regulations of the Office of the Secretary of Transportation, 49 CFR 1.49(c).

2. Section 232.13 is proposed to be amended by revising paragraphs (b), (c) and (d) (1) and (d) (2) (i), and by adding paragraphs (g) and (h) to read as follows:

**§ 232.13 Road Train and intermediate terminal train air brake tests.**

(a) * * *

(b) *Freight trains.* Before motive power is detached or angle cocks are closed on a freight train, brakes must be applied with not less than a 20-pound brake pipe reduction. After recoupling, and after angle cocks are opened, it must be known that brake pipe air pressure is being properly restored as indicated by a rear car gauge or device. In the absence of a rear car gauge or device, or in the event the rear car gauge or device is inoperative for any reason, an air brake test must be made to determine that the brakes apply and release on the last car.

(c) (1) At a point other than an initial terminal where a locomotive or caboose is changed, or where one or more consecutive cars are cut off from the rear end or head end of a train with the consist remaining otherwise intact, after the train brake system is charged to within 15 pounds of the feed valve setting on the locomotive, but not less than 60 pounds as indicated at the rear of a freight train and 70 pounds on a passenger train, a 20-pound brake pipe reducton must be made and it must be determined that brake pipe pressure is being reduced at the rear of the train as indicated by a rear car gauge or device. Before proeeding it must be known that brake pipe pressure as indicated at the rear of a freight train is being restored as indicated by a rear car gauge or device.

(2) On trains operating with electro-pneumatic brakes, with the brake system charged to not less than 70 pounds, a test must be made to determine that rear brakes apply and release properly from a minimum 20-pound electro-pneumatic brake application as indicated by the brake cylinder gauge.

(d) (1) At a point other than a terminal where one or more cars are added to a train, after the train brake sytem is charged to not less than 60 pounds as indicated by a gauge or device at the rear of a freight train and 70 pounds on a passenger train, a brake test must be made to determine that brake pipe leakage does not exceed five (5) pounds per minute as indicated by the brake pipe gauge after a 20-pound brake pipe reduction. After this test is completed, it must be known that the brakes on each of these cars and the rear car apply and release. Before proceeding it must be known that brake pipe pressure at the rear end of the train is being restored as indicated by a rear car gauge or device. In the event that the rear car gauge or device is inoperative for any reason, an air brake test mut be made to determine that the brakes apply and release on the last car. Cars added to a train that have not been inspected in accordance with § 232.12(c)–(j) must be so inspected and tested at the next terminal where facilities are availble for such attention.

(2) (i) At a terminal where a solid block of cars, which has been previously charged and tested as prescribed by § 232.12(c)–(j), is added to a train, after the train brake system is charged to within 15 pounds of the feed valve setting on the locomotive, but not less than 60 pounds as indicated at the rear of a freight train and 70 pounds on a passenger train, a 20-pound brake pipe reduction must be made and it must be determined that pressure is being reduced at the rear of the train as indicated by a rear car gauge or device. Before proceeding it must be known that the brake pipe pressure at the rear of the freight train is being restored and indicated by a rear car gauge or device. In the event the gauge or device is inoperative for any reason, an air brake test must be made to determine that the brakes apply and release on the last car.

(ii) * * *

(g) As used in this section, "device" means a device that—

(1) Accurately determines the brake pipe pressure on the rear car of a train on a continuous basis during train operations;

(2) Conveys the rear car brake pipe pressure on a continuous basis during train oprations in not more than one pound increments to the cab of the controlling locomotive; and

(3) Displays the quantitative value in a manner readily visible in daylight and darkness from the engineer's normal operating position.

(h) The accuracy of the device to be used to comply with the test procedures in this section shall be determined as part of the initial terminal air brake test. After charging the train, the rear car brake pipe pressure reading of the device shall be cross checked with the reading of a gauge at the rear of the train. The device may not be used if the difference between the two readings exceeds three pounds.

Issued in Washington, DC, on August 26, 1985.

**John H. Riley,**

*Administrator.*

[FR Doc. 85–20741 Filed 8–30–85; 8:45 am]

BILLING CODE 4910-06-M

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**49 CFR Part 232**

**[Docket No. RSSI–85–1, Notice No. 1]**

## Special Safety Inquiry; Railroad Power Brakes

**AGENCY:** Federal Railroad Administration (FRA), DOT.

**ACTION:** Notice of Special Safety Inquiry.

**SUMMARY:** FRA is initiating a Special Safety Inquiry to obtain information from the public to assist in evaluating the impact of the changes in the power brake regulations made in August of 1983 in Docket PB–6. This information will be used in assessing whether further regulatory action to modify the 1982 power brake changes is appropriate.

**DATES:**

(1) A public hearing will begin at 10:00 a.m. on October 25, 1985.

(2) Prepared statements to be made at the hearing should be submitted to the Docket Clerk at least seven days before the hearing date.

(3) Persons desiring to participate at the hearing should notify the Docket Clerk at least seven days before the hearing.

(4) Persons desiring to submit written comments for inclusion in the safety inquiry docket should submit them by Ocober 18, 1985.

**ADDRESSES:**

(1) Hearing location—Room 7200, Nassif Building, 400 Seventh Street, S.W., Washington, D.C. 20590

(2) Docket Clerk, Office of Chief Counsel (RCC–30), Federal Railroad Administration, Washington, D.C. 20590. Telephone 202–426–8285.

**FOR FURTHER INFORMATION CONTACT:**

*Principal Program Person:* Philip Olekszyk, Deputy Associate Administrator for Safety, Federal Railroad Administration, Washington, D.C. 20590. Telephone 202–426–0897.

*Principal Attorney:* Michael E. Chase, Office of Chief Counsel, Federal Railroad Administration, Washington, D.C. 20590. Telephone 202–426–8285.

**SUPPLEMENTARY INFORMATION:** On August 23, 1982, FRA published a final rule (47 FR 36792–36795) amending the regulations relating to railroad power brakes (49 CFR Part 232). The changes included extension of the intermediate inspection interval in § 232.12 from 500 to 1,000 miles and extension of the maximum permissible piston travel limit in § 232.11 from 10 inches to 10½ inches.

These changes were responsive to a joint recommendation by rail labor and rail management contained in a letter to FRA dated November 6, 1981. The letter also requested that at the end of two years a review by made of relevant statistical data to determine if the elimination of a mileage requirement for the intermediate inspection is appropriate and if further extension of the piston travel limit is appropriate. In the preamble to the final rule, FRA committed itself to "closely monitor" the impact of the changes and to take action as warranted.

Now that two full calendar years (1983 and 1984) have elapsed since the rule changes became effective, years for which accident data has been obtained and published, FRA has concluded that all interested persons should be afforded an opportunity to assess the impact of the 1982 changes. Hence, FRA is holding a power brake safety inquiry to obtain information from the public to assist its evaluation of the impact of the 1982 revision of the power brake regulations. This information will be used in deciding whether further regulatory action to modify the 1982 changes is warranted.

**Public Participation**

FRA encourages all interested persons to participate in this Special Safety Inquiry. Persons desiring to participate may do so by submitting written comments for inclusion in the Safety Inquiry docket and by participating in the public hearing that will be held on October 25, 1985, in Washington, D.C.

Persons desiring to participate in the hearing should notify the Docket Clerk at least seven days before the hearing and indicate the amount of time they will need to present their views. Prepared statements also should be submitted at least seven days before the hearing date to the Docket Clerk.

Issued in Washington, D.C. on August 28, 1985.

(Secs. 202 and 209, Federal Railroad Safety Act of 1970 (45 U.S.C. 431 and 437), Sec. 1.49(n) of the regulations of the Office of the Secretary, 49 CFR 1.49(n))

John H. Riley,

*Administrator.*

[FR Doc. 85–20740 Filed 8–30–85; 8:45 am]

BILLING CODE 4910–06–M

federal register

Tuesday
September 3, 1985

Part III

# Department of Health and Human Services

Health Care Financing Administration

42 CFR Parts 405 and 412

Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1986 Rates; Final Rule

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Health Care Financing Administration**

**42 CFR Parts 405 and 412**

**[BERC-315-F]**

# Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1986 Rates

**AGENCY:** Health Care Financing Administration (HCFA), HHS.

**ACTION:** Final rule.

**SUMMARY:** We are modifying the Medicare inpatient hospital prospective payment system in order to implement necessary changes arising from experience with the system. In addition, this final rule sets forth our first adjustment of the diagnosis-related group weights and classifications as required under section 1886(d)(4)(C) of the Act.

Also, in the addendum to this final rule, we are describing changes in the methods, amounts, and factors necessary to determine prospective payment rates for Medicare inpatient hospital services. Changes to the Federal portion of the payment are applicable to discharges occurring on or after October 1, 1985.

Changes to the hospital-specific portion are effective with hospital cost reporting periods beginning on or after October 1, 1985. In effect, these changes apply to the final year of the three-year transition period for the hospital prospective payment system. The addendum also sets forth the rate-of-increase limits (target amounts) for hospitals excluded from the prospective payment system.

**EFFECTIVE DATE:** With certain exceptions, this final rule is effective on October 1, 1985. We refer the reader to section VII.A. of this preamble for a detailed discussion of effective dates.

**FOR FURTHER INFORMATION CONTACT:**

Linda Magno (301) 594-9343—DRG Recalibration, Hospital Wage Index, New Hospital Exemption from Rate of Increase, Payment for Cost Outliers, Referral Centers, Indirect Medical Education, Transfer Policy, Prospective Payment Rates, Excluded Hospitals

Thomas Hoyer (301) 594-9446—DRG Reclassification, GROUPER Program, Alcohol/Drug Hospitals and Units, Review Activities

**SUPPLEMENTARY INFORMATION:**

## I. Background

### *A. Summary of the Implementation of the Prospective Payment System*

Under section 1886(d) of the Social Security Act (the Act), enacted by the Social Security Amendments of 1983 (Pub. L. 98-21) on April 20, 1983, a prospective payment system for Medicare payment of inpatient hospital services was established effective with hospital cost reporting periods beginning on or after October 1, 1983. Under this system, Medicare payment is made at a predetermined, specific rate for each discharge. All discharges are classified according to a list of diagnosis-related groups (DRGs). This list currently contains 470 specific categories.

Section 1886(d)(1) of the Act provides for a three-year transition period during which a declining portion of the total prospective payment rate is based on a hospital's historical cost in a given base year, and a gradually increasing portion is based on a Federal rate per discharge. The Federal rate is based on regional average standardized hospital costs in the first year, and a blend of a regional and national rates per discharge in the second and third years. Beginning with the fourth year (that is, October 1, 1986), and continuing thereafter, the Federal portion of the payment for inpatient hospital services will be based entirely on national payment rates.

We published an interim final rule in the **Federal Register** (48 FR 39752) on September 1, 1983 to implement the prospective payment system effective with hospital cost reporting periods beginning on or after October 1, 1983. Technical corrections for that rule were issued on October 19, 1983 (48 FR 48467). In that rule, we established criteria for determining—

- Which hospitals are included in or excluded from the prospective payment system;
- The basis of payment under the prospective payment system;
- The prospective payment rate methodology;
- Additional payment amounts;
- Special treatment of certain hospitals; and
- Other conforming changes.

In particular, we identified the prospective payment rates to be used for the first year of the transition period. We issued a final rule (49 FR 234) on January 3, 1984 to make changes resulting from our consideration of public comments that were received in response to the interim final rule. Technical corrections for that rule were issued on June 1, 1984 (49 FR 23010).

As a result of our first year of experience with the prospective payment system and to accommodate changes resulting from the enactment of the Deficit Reduction Act of 1984 (Pub. L. 98-369) on July 18, 1984, we published a final rule on August 31, 1984 (49 FR 34728) that further revised the prospective payment regulations. In addition, in the addendum to that final rule, we described changes in the methods, amounts, and factors necessary to implement the second year of the payment transition period. Changes in the Federal rates were applicable to discharges occurring on or after October 1, 1984, while changes regarding the hospital-specific portion of the payment were effective with hospital cost reporting periods beginning on or after October 1, 1984. Technical corrections on that final rule were issued on October 15, 1984 (49 FR 40167).

On March 29, 1985, we published a final rule (50 FR 12740) that redesignated the prospective payment regulations under a new 42 CFR Part 412. These regulations were previously located in 42 CFR 405.470 through 405.477.

### *B. Summary of June 10, 1985, Proposed Rule*

On June 10, 1985, we published a notice of proposed rulemaking (NPRM or proposed rule) in the **Federal Register** (50 FR 24366) to further amend the prospective payment system. We proposed to make the following changes:

- As required by section 1886(d)(4)(C) of the Act, we proposed to adjust the classifications and weighting factors for discharges beginning with Federal fiscal year (FY) 1986.
- We proposed to use a new wage index for purposes of adjusting for variations in area wage levels. The proposed new wage index is based on a HCFA survey of hospitals and would be used in standardizing hospital costs for purposes of determining the Federal rate, in standardizing hospital charges for purposes of recalibrating the DRG weights, and for adjusting the Federal rate for purposes of determining prospective payments for hospitals.
- We discussed several current provisions of the regulations in 42 CFR Parts 405 and 412 and set forth certain proposed changes concerning—

—Exemptions for new hospitals from the rate-of-increase limits;
—Payments for indirect costs of medical education;
—Limitations on charges to beneficiaries for hospitals paid under State reimbursement control systems or demonstration projects;
—Payment for cost outliers; and
—Referral center qualifying criteria.

We also proposed several conforming changes to the regulations.

• In the addendum to the proposed rule, we set forth proposed changes to methods, amounts and factors for determining the FY 1986 prospective payment rates. We also proposed new target rate percentages for determining the rate-of-increase limits for FY 1986 for hospitals excluded from the prospective payment system.

In addition, the proposed rule discussed in detail the recommendations made by the Prospective Payment Assessment Commission (ProPAC). ProPAC is directed by section 1886(d)(4)(D) of the Act to make recommendations to the Secretary with respect to adjustments to the DRG classification and weighting factors and to report to Congress with respect to its evaluation of any adjustments made by the Secretary.

ProPAC is also directed, by the provisions of section 1886(e)(2) and (e)(3) of the Act, to make recommendations to the Secretary on the appropriate percentage change factor to be used in updating the average standardized amounts beginning with FY 1986. These recommendations are due to the Secretary no later than the April 1 preceding each Federal fiscal year. The statute requires that ProPAC, in making its recommendations, take into account changes in the hospital market basket, hospital productivity, technological and scientific advances, the quality of health care provided in hospitals, and long-term cost effectiveness in the provision of inpatient hospital services. As required under section 1886(e)(5) of the Act, we published the report of the recommendations from ProPAC as Appendix C to the proposed rule.

*C. Number and Types of Public Comments*

A total of 2,201 letters containing comments on the proposed regulations were received by the end of the comment period (July 10, 1985). Among the many issues addressed in the proposed rule, the following subjects received the majority of comments:

• The zero percent increase in the prospective payment rates.

• Proposed wage index based on the HCFA survey.

• Count of interns and residents for determining the indirect medical education payment.

• The recalibration of the DRG weights.

• Revision of the alcohol/drug DRGs and termination of the exclusion for alcohol/drug hospitals and units. (We received 2,025 form or nearly identical letters from individuals on this issue as well as several other comments.)

The contents of the proposed rule, the public comments, and our responses to the comments are discussed throughout this document in the appropriate sections. However, we are responding to a general comment here rather than in one of the more issue-specific areas below.

*Comment:* Several commenters objected that the 30-day comment period afforded them in the proposed rule was too short. They believe that this amount of time was inadequate to allow the hospital industry to evaluate thoroughly the complex issues included in that proposed rule. One commenter suggested that the September 1 final rule be published as an interim final rule with comment period in order to give the public additional time to evaluate the issues and submit further comments.

*Response:* When we issued the proposed rule, we recognized the importance of affording the public the fullest opportunity to analyze the many issues raised in the document and to express their views. In fact, in several places in the proposed rule, we specifically invited comments on particular issues. However, under section 1886(e)(5)(B) of the Act, we are required to publish final regulations and rates for FY 1986 by September 1, 1985. Since we could not publish the proposed rule until we had reviewed ProPAC's April 1, 1985 recommendations and taken them into account, there was insufficient time available for a public comment period of more than 30 days between the publication of the proposed rule and the required date of publication of the final rule. Under these constraints, we had no choice but to limit the comment period on the proposed rule to 30 days and to proceed with publication of the final regulations and rates for FY 1986 by September 1, 1985.

As to the comment that we should issue an interim final rule with comment period by September 1 instead of a final rule, we again refer to the specific language in section 1886(e)(5)(B) of the Act, which provides that:

> The Secretary shall cause to have published in the **Federal Register**, not later than . . . the September 1 before . . . [the next ensuing Federal] fiscal year after such consideration of public comment on the proposal as is feasible in the time available, the Secretary's final determination . . .

The statute is implemented by regulations at 42 CFR 412.8(b)(3), which state that:

> HCFA will publish a **Federal Register** notice setting forth final . . . prospective payment rates not later than the September 1 before the Federal fiscal year in which the rates would apply.

The statutory language clearly anticipates that *final* prospective payment rates will be issued each year by September 1. Publication by that date is intended to give the industry a full 30 days in which to make whatever adjustments may be necessary to implement the provisions of the final rule by October 1 (the beginning of FY 1986).

If we were to issue an interim final rule with comment period, we would be obligated to consider whatever further public comments we receive. Conceivably, this could result in modifications based on the comments that might alter in some respect the finality of the FY 1986 prospective payment system rates. This in turn would undermine the certainty, so essential to the prospective payment system, that is gained by issuing a final rule by a specified date. Under section 1886(e)(5)(B) of the Act, we are required to establish clear payment policy and prospective payment rates in advance of the fiscal year to which the policy and rates will apply. Issuing an interim final rule with comment period instead of a final rule at this point would serve only to introduce uncertainty into the process and would also raise the prospect of retroactive adjustments that might be necessary to accommodate any later decisions arising from the interim rule.

**II. Changes to DRG Classifications and Weighting Factors**

Under the prospective payment system, we pay for inpatient hospital services on the basis of a rate per discharge that varies by the DRG to which a beneficiary's stay is assigned. The formula used to calculate payment for a specific case takes an individual hospital's payment rate per case (comprised of a hospital-specific portion and an urban or rural Federal portion adjusted for area wages) and multiplies it by the weight of the DRG to which the case is assigned. Each DRG weight represents the average resources required to care for cases in that particular DRG relative to the national average resources consumed per case by the average hospital. Thus, cases in a DRG with a weigh of 2.0 would, on average, require twice as many resources as the average case for the average hospital.

Congress recognized that it would be necessary to recalculate the DRG relative weights periodically to account for changes in resource consumption. In addition, Congress provided the

Secretary with authority to reclassify services and procedures within the DRG system to take into account changes in medical technology and treatment patterns. Accordingly, section 1886(d)(4)(C) of the Act requires that the Secretary adjust the DRG classifications and weighting factors effective for discharges occurring in FY 1986 and at least every four fiscal years thereafter. These adjustments are made to reflect changes in resource consumption, treatment patterns, technology, and any other factors that may change the relative use of hospital resources. The intention of Congress was that we would make changes as often as needed to achieve the objectives of the prospective payment system, including the need to keep current with developments in the areas of coverage and medical technology. The DRG reclassifications and the recalibration for discharges occuring on or after October 1, 1985 are set forth below.

*A. Basic Classification System*

The method of classifying cases into DRGs for payment under the prospective payment system involves a number of steps. The intermediary enters medical and other information contained in each patient's bill into its claims system and subjects it to a series of automated screens called the Medicare Code Editor. These screens are designed to identify cases that require further review before classification into a DRG can be accomplished.

After screening through the Medicare Code Editor and any further development of the claims, cases are classified by GROUPER into the appropriate DRG. The GROUPER software program was developed as a means of classifying each case into the appropriate DRG on the basis of the diagnosis and procedure codes and demographic information, that is, sex, age, and discharge status. It is used both to classify past cases in order to establish the DRG weights and to classify current cases for payment.

During the initial operating period of the prospective payment system, we learned that the use of the DRG method of classification posed some operational challenges that we needed to address further. In the NPRM, we proposed a number of improvements to the DRG classification system and included them in a revised GROUPER program that was used to develop the recalibrated DRG weights published in the addendum to the proposed rule (Table 5). The revised GROUPER program would be used to classify and assign cases to DRGs effective with discharges occurring on or after October 1, 1985.

We listed all the proposed changes made to GROUPER in Table 6 of the addendum to the NPRM. The following is a brief description of the general categories of proposed changes.

1. DRG Logic Issues and Technology Changes

We proposed that some GROUPER logic decisions be improved and others be corrected to reflect technological advances that have occurred since the development of the classification system. For example, as a method of solving a technology and coding problem, we proposed to move percutaneous transluminal coronary angioplasty from DRG 108 (Cardiothoracic Procedures, Except Valve and Coronary Bypass, With Pump) to DRG 112 (Vascular Procedures Except Major Reconstruction).

*Comment:* A few commenters suggested that percutaneous transluminal coronary angioplasty be assigned to DRG 109 (Cardiothoracic Procedure Without Pump), based on another view of the appropriate clinical placement of the procedure. Other commenters suggested that the change, as we described it, did not achieve our objective, because it failed to account for some cases that include open chest procedures. Many of the commenters agreed with the DRG 112 assignment.

*Response:* We are persuaded by our analysis and by ProPAC's recommendation that DRG 112 is the best assignment for percutaneous transluminal coronary angioplasty. Both DRGs 108 and 109 consist of major open cardiothoracic procedures with or without a cardiac bypass pump. Neither DRG is appropriate for percutaneous transluminal coronary angioplasty because, in order to perform the procedures listed in these DRGs, it is necessary to enter the chest surgically and expose the heart, as well as to perform surgery directly on the heart muscle or heart valves.

Percutaneous transluminal coronary angioplasty is not an operation that requires open chest surgery on the heart. Instead, a catheter is inserted in an artery in the arm or leg and is passed into the vessels that supply the heart muscle. Only a very small incision in the arm or leg is made and the chest is not opened. The procedure is carried out directly on the heart vessels but not on the heart muscle itself. This procedure is most closely related clinically to the procedures in DRG 112, which are procedures on the vessels of the body.

With respect to resource consumption, we believe DRG 112 is appropriate. Our data for FY 1984 indicate that the average charge for an uncomplicated percutaneous transluminal coronary angioplasty case was well within the range of charges for other cases that fall within DRG 112 and, in fact, is less resource intensive than many of the other cases within that DRG. Thus, we believe that the resource range required for this procedure fits within the DRG to which it is assigned.

We have, however, also noted comments on the NPRM that our proposed changes did not accomplish the result we desired because they do not permit those cases that entail use of a pump (code 39.61) to continue to be classified in DRG 108. We are correcting this omission in this document. We note that we published the changes as a proposal to elicit comments and corrections such as these.

We recognize that percutaneous transluminal coronary angioplasty is a significantly less invasive procedure than the one that it replaces and we are particularly concerned to assure that its placement in this DRG not create an incentive to continue to use more complex and invasive procedures. As we have noted, we believe that this assignment is appropriate from the standpoint of resource consumption and clinical coherence; however, as recommended by ProPAC, we will continue to monitor this issue to assure that placement of percutaneous transluminal coronary angioplasty cases in DRG 112 is appropriate from the perspective of both clinical characteristics and resource utilization.

2. Operating Room versus Non-Operating Room Assignment

The distinction between medical and surgical DRGs is meant to reflect the difference between cases that use operating rooms (a significant additional resource) and cases that do not. However, a few procedures that do not require the use of an operating room are recognized by GROUPER as operating room procedures. As we proposed, we are deleting these procedures from the list of procedures that could result in assignment to a surgical DRG in order to assure that the cases that included them as the only surgical procedure are classfied appropriately for payment purposes.

3. Complication and Comorbidity Membership

In some cases, DRGs are listed in pairs, one with and one without complications or comorbidities, with a higher weight generally assigned to the DRG that includes complication or comorbidity. We proposed to add a number of additional diagnostic and

procedural codes (mostly traumatic amputation codes) to the list of complications and comorbidities. The changes we are making will allow cases with these additional codes to be classified in DRGs that reflect the additional resources necessary to deal with complications or comorbidities.

4. Surgical Hierarchy Changes

An examination of length of stay and charge data has led us to reorder in the hierarchy of surgical procedures in a few cases, as we proposed in the NPRM.

5. DRG 468 (Unrelated OR Procedure) Issues

We proposed to modify a number of Major Diagnostic Categories (MDCs) and DRGs to include International Classification of Diseases, Ninth Edition, Clinical Modification (ICD–9–CM) codes for surgical procedures that may be performed for diagnoses within them but that are not currently reflected in the GROUPER program that is used to assign cases to the particular MDC or DRG. Thus, with these changes, cases in which these procedures are performed will be recognized by GROUPER and properly classified in the appropriate DRG rather than DRG 468, where they are currently classified.

*Comment:* We received two comments on our list of operating room procedures that we proposed to add to the various DRGs so that assignment of cases to DRG 468 would be reduced. One commenter believes that the reassignment of some cases to DRGs 269 and 270 would reduce payments to the hospital for these procedures. Another commenter questioned whether the reassignment of these cases would mar the clinical homogeneity of the DRGs to which they will now group.

*Response:* Most of the procedures added to the various DRGs are relatively minor and were omitted from the original DRG system (and GROUPER software) through oversights. They are all clinically suited to the DRGs where they will now be grouped. Since the weights for all the DRGs that are set forth in Table 5 have been established using the revised GROUPER program, they accurately reflect the resources expended on all the cases that fall within them, including the cases that will be reassigned to them from DRG 468. Thus, the DRGs continue to be clinically homogeneous and any increase or decrease in payment for an individual case that previously would have grouped to DRG 468 will be an appropriate result of the changes.

In addition to these proposed revisions, we made a number of clarifying revisions in the documentation that describes how GROUPER works. Anyone interested in obtaining materials that reflect these changes may purchase revised GROUPER software and ICD–9–CM user manuals from:

Health Systems International, 100 Broadway, New Haven, Connecticut 06511.

As in the proposed rule, a listing of the changes appears in Table 6 of the addendum to this final rule.

*B. Reclassification of DRGS*

In addition to the generic types of changes discussed above, we also proposed to make changes in the DRG classification system for alcohol and drug abuse DRGs, certain major joint procedures, and kidney transplants for diabetic patients. We believed that the proposed changes would improve the accuracy of the classification system and, along with the use of FY 1984 claims data, would result in the establishment of more accurate weights. These changes should also strengthen the relationship between the consumption of resources in the cases whose assignments are affected by these changes and the payments made for these cases.

Set forth below are our responses to some general comments on DRG classification that we received. Comments related to our specific proposals are discussed later in this section.

*Comment:* A number of commenters made suggestions about DRG changes that reflected misconceptions as to the design of the system and manner in which the system works. A frequent comment was that one DRG or another should be given a higher weight to reflect the cost of caring for patients who may require more than the average intensity of services or to reflect the intensity of services associated with a particular clinical regimen favored by the commenter. Also, a number of comments dealt with cases in which a patient requires additional services unrelated to the principal diagnosis.

*Response:* We stress that the weights assigned to the various DRGs reflect the actual average intensity of services provided to patients whose cases fall within them. As we have noted, we used the FY 1984 Part A Tape Bill (PATBILL) file to establish the weights and are satisfied that they adequately reflect the intensity of services provided. We also note that both day and cost outlier payments are available for cases that are extraordinarily costly or for which the inpatient stay is prolonged. Finally, we noted that the geometric mean lengths of stay shown in the DRG listing (see Table 5) are not intended to be an expression of the typical length of stay for the DRG. Their main purpose is to serve as a benchmark for the computation of outlier payments. In fact, the arithmetic mean length of stay, which is typically longer, is the more common measure of the "average" stay for the DRGs. We have printed the arithmetic mean lengths of stay in Table 5 of the addendum to this final rule as a point of information for reviewers. We note that, with the exception of outlier cases, the weight assigned to a DRG reflects the average resource utilization for cases that fall within it even though some cases will require more or fewer resources. The system is designed so that, on balance, the aggregate Medicare payment to hospitals in a locality should be adequate for the aggregate Medicare utilization.

*Comment:* Various commenters suggested that the methodology by which reclassification issues were treated should be fully explained in connection with any proposed changes and that any difference in the payment for individual cases that may be moved from one DRG to another by such reclassifications should be fully discussed.

*Response:* As we have noted, we continue to employ the basic principles that were used for the original construction of the DRG system and that have been described in a variety of documents that are available to individuals who desire additional information. (See the September 1, 1983 interim final rule (48 FR 39761).)

Since the purpose of the system is to assure that cases are classified into DRGs that are both clinically coherent and that typically require a comparable range of resources, we do not believe that relative increases or decreases in payments for individual cases (so long as they fall within the general resource range) are relevant. We stress again that the classification system aims toward an aggregate payment that is appropriate for the sum of all cases, not payments that are based upon variations in resource consumption in individual cases. Thus, comments that are primarily anecdotal or that argue that payment should be based on a commenter's desired clinical practice (rather than actual resources used) have not been accepted.

*Comment:* A number of commenters suggested further changes in DRG classification or suggested further refinements of the changes we proposed.

*Response:* We have included in this final rule the changes we proposed (as revised on the basis of comments) as

well as certain other changes (for example, certain Grouper logic changes) that were suggested that we judged to be similar and complementary to the changes we discussed in the proposed rule. These changes are listed in Table 6 of the addendum. We have not discussed all these changes in detail in this document, but we have discussed briefly the changes in which we believe there was the most public interest. Other changes suggested by commenters will be dealt with in a separate notice, which we propose to publish early in 1986.

1. Alcohol and Drug Abuse DRGs

In the January 3, 1984 final rule, we excluded alcohol/drug treatment hospitals and units from the prospective payment system in response to criticism we received concerning the alcohol and drug abuse DRGs (49 FR 241). In that document, we specified that the exclusion would be permitted only until October 1, 1985, and that after that date we intended to include an adjustment to the DRG classification system that would permit prospective payment to be made appropriately for alcohol/drug treatment services. (See section IV of this preamble for a further discussion of the expiration date of this exclusion.)

In order to properly reclassify these DRGs, we consulted with medical experts of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), the National Institute on Alcohol Abuse and Alcoholism (NIAAA), and the National Institute of Mental Health. The analysis we performed was explained in detail in the proposed rule (50 FR 24370). The following is the proposed reclassification of the substance abuse DRGs within MDC 20 (Substance Use and Substance Induced Organic Mental Disorders):

- DRG 433—Substance Use and Substance Induced Organic Mental Disorders, Left Against Medical Advice.
- DRG 434—Substance Abuse, Intoxication, or Induced Mental Syndrome Except Dependence.
- DRG 435—Substance Dependence, Detoxification and/or other Symptomatic Treatment.
- DRG 436—Substance Dependence, Rehabilitation Therapy.
- DRG 437—Substance Dependence, Combined Rehabilitation and Detoxification Therapy.

The vast majority of letters we received were commenting on this proposal. The specific issues raised by those commenters are set forth below.

*Comment:* A number of commenters suggested that DRG 437 should be reweighted to allow payment for a mean length of stay of 16.9 days. The commenters argued that the course of rehabilitation for patients in DRG 437 requires a longer stay than the number of days shown as the geometric mean length of stay for this DRG (14.6).

*Response:* First of all, we wish to clarify that the length of stay data published along with the table of weights is neither prescriptive nor in any way intended to reflect limits on Medicare inpatient hospital benefits. Indeed, as long as an admission is medically necessary and the beneficiary has not exhausted his or her benefits, Medicare's payment to the hospital, except for outlier payments, is the same regardless of whether the patient remains hospitalized for one day or for one month. Each length-of-stay statistic represents the geometric mean of a distribution of hospital cases, some of which had lengths of stay considerably below the published mean and others that had lengths of stay considerably above the published means. In fact, although the geometric mean length of stay for DRG 437 is 14.6 days, the arithmetic mean length of stay, which is the measure of average length of stay for a DRG, is 18.9 days.

We have every reason to expect that the medical community will continue to concern itself with furnishing medically appropriate care to Medicare beneficiaries and that standards of care in particular cases will not be artificially constrained by published length of stay data that represent population means, not ranges.

We believe that these commenters may have misunderstood the principles upon which the DRG system is based. The recommendations we have received were apparently from commenters who added the separate geometric mean lengths of stay proposed for DRGs 435 and 436, and who have inferred that the lengths of stay and weights are based on a clinical assumption about the length of covered stay for both detoxification and rehabilitation. Our DRG system, however, is based on the actual medical practices of all hospitals that are subject to the prospective payment system and provide the services reflected in the DRG. The more than 38,000 claims we used to derive the weights of these DRGs came from nearly 4,500 different hospitals that submitted claims for these services in FY 1984. Since the DRG weights are based on the actual practice of the hospital furnishing care to the cases in question, it would not be appropriate to adjust the weights of one of them to reflect the views of a small group of providers with specific clinical preferences. We have therefore rejected this comment.

*Comment:* Some commenters noted that some drug-dependent or drug-intoxicated individuals who are dependent on multiple drugs may require a significantly longer period for detoxification and rehabilitation than is reflected in the DRGs. They question whether our proposed DRGs are adequate for these individuals.

*Response:* As we have noted before, the weight of any DRG is an approximate average of the cost of treating all Medicare cases that fall within it. We believe that the universe of claims we used to establish these weights was large enough to reflect some relatively long and short stay cases and that, on balance, the payments we make under these DRGs will adequately compensate hospitals treating the patients whose cases fall within them. For extremely long stay cases or extraordinarily expensive cases, of course, outlier payments are also available.

While it may be true, especially in a younger population, that the resources used in treating other drug problems may be greater than those used in treating alcohol alone, our data do not show that there is a difference of significant magnitude to warrant making this distinction between alcohol and drug problems in the Medicare beneficiary population. We do agree, however, that populations that include a significant number of younger patients (for example, Medicaid recipients) may have different overall characteristics and may require different DRG configurations. Moreover, we would expect the weights, not only for the substance abuse DRGs but for all DRGs, to vary substantially depending on the patient population on whose hospital experience the weights are based.

*Comment:* One commenter questioned whether the sample size of 5,577 cases used in studying the appropriateness of the proposed reconfiguration of the DRGs in MDC 20 was adequate, and whether the 1,112 providers in the sample were representative of the population of providers nationwide.

*Response:* It is important to note that the sample data were used solely to study the appropriateness of the proposed reconfiguration of the alcohol and drug abuse DRGs. These data were not used in deriving the relative weights reported in the proposed rule on June 10, 1985 (50 FR 24416). In order to treat the DRGs in MDC 20 consistently with the other DRGs, the larger recalibration data set was used in deriving the relative weights for the alcohol and drug abuse DRGs. However, statistical tests revealed that, with the exception of

DRG 433 (for which the sample did not contain a sufficient number of cases to generate a reliable estimate and which, in addition, was unaffected by the proposed reconfiguration of the DRGs), there were no significant differences between the mean charges for each DRG in the study sample and the mean charges in the larger recalibration data set.

The distribution by DRG of the 5,577 cases used in the study was as follows:

DRG 433—201
DRG 434—685
DRG 435—2,712
DRG 436—1,357
DRG 437—622

With the exception of DRG 433, the sample sizes were sufficiently large to conclude that our estimated mean charges for each DRG are within 10 percent of the true means with 95 percent confidence.

A chi-square test to determine how well the distribution of sample providers (that is, short-term general hospitals, alcohol and drug treatment hospitals, alcohol and drug units) matched the distribution of the population of providers with cases in the alcohol/drug DRGs revealed significant differences between the observed distribution of our sample of providers and the distribution of providers nationwide. In particular, alcohol and drug treatment hospitals and units of short-term general hospitals were overrepresented in our sample of providers, whereas short-term general hospitals without alcohol and drug treatment units were underrepresented in our sample. Despite these differences between the sample and the universe of hospitals, however, the means charges estimated from the sample were not significantly different from the mean charges obtained from the recalibration data set. Thus, there is no analytic basis for substituting weights derived from a sample for weights derived from essentially the universe of Medicare cases in these or any other DRGs.

*Comment:* Several commenters suggested that the revised alcohol/drug DRGs are overpaying for detoxification therapy relative to rehabilitation therapy.

*Response:* The relative weights of each DRG and the geometric mean lengths of stay are derived from actual consumption of resources as reflected in the 1984 Medicare PATBILL file and, thus, directly tracks the use of hospital resources to provide these services. In considering which services contributed to the weight derived for the DRG, it should be noted that many cases involve not only detoxification for drugs as well as alcohol but other symptomatic treatment as well. We note that if hospitals code cases inaccurately, here, as elsewhere, it could adversely affect payments and classifications in subsequent years, since we will continue to update the system based on the latest data available. While data submitted by hospitals is subject to review and correction, review activity is limited to samples. Therefore, we must view the bulk of the information furnished by hospitals as accurate and reflective of current hospital practices.

*Comment:* One commenter noted that patients with psychosis in alcohol dependence represented by ICD–9–CM codes 291.3, 291.8, 291.9 are not able to benefit from rehabilitative therapy while in a psychotic state and that their inclusion in DRGs 436 and 437 is inappropriate.

*Response:* We agree and are programming the GROUPER system so that these codes will group only to DRG 435 (Detoxification and Other Symptomatic Treatment).

*Comment:* One commenter noted that ICD–9–CM code 303.03 (Alcohol dependence syndrome in remission) presents ambiguities that suggest that every case may not be appropriate for inpatient rehabilitation.

*Response:* We agree and will institute prepayment review of cases that show this code as the principal diagnosis.

*Comment:* Several commenters noted that persons with an alcohol or drug problem with an ICD–9–CM code that does not indicate dependence may still have a medical need for detoxification.

*Response:* We agree and are revising the title of DRG 434 to read "Substance Abuse, Intoxication, or Induced Mental Syndrome Except Dependence; Detoxification and/or Other Symptomatic Treatment."

*Comment:* One commenter indicated that most alcohol and drug abuse patients can be treated on an outpatient basis or in the home through the use of primarily medical and social treatment. It was suggested that increased payments for these DRGs was inappropriate.

*Response:* We agree that there are many settings in which both detoxification and rehabilitation may take place and that some of these settings are social and nonmedical. We believe, however, that some patients do require inpatient care for detoxification, rehabilitation, and other symptoms associated with alcohol and drug abuse. Our coverage rules explicitly indicate that inpatient care is only covered when it is medically necessary and, therefore, we would expect that inpatient hospital stays for those patients whose care could appropriately be provided in social and nonmedical settings would be denied as noncovered care.

*Comment:* One commenter suggested that the significantly higher weights assigned to DRGs that involve rehabilitation and combined detoxification and rehabilitation could create an incentive for misrepresenting cases in order to obtain increased payments.

*Response:* As we noted in the proposed rule, we believe that this potential problem can be solved by enhanced review by PROs. PROs will be asked to increase admission review of alcohol and drug abuse cases and also to increase attention to these cases during DRG validation. We believe that PRO review is adequate to prevent inappropriate payment.

2. Major Joint Procedures (DRG 209)

Hospitals, physicians, and professional societies allege that our current DRG 209 creates a disincentive for performing more than one medically-appropriate major joint procedure of the lower extremity during the same hospital stay. We have been told that some patients may be undergoing two separate hospitalizations when, in fact, the performance of both joint replacements during the same hospital stay might be more appropriate medically. This disincentive results from the high cost of each artificial joint prosthesis as well as the differing clinical course of patients who require this surgery and the nature of the postoperative rehabilitation process associated with lower extremity joint replacement.

Based on consultation with various professional organizations and individual physicians, including the American Academy of Orthopaedic Surgeons and the American College of Surgeons, and a review of all Medicare claims in our 1984 PATBILL file through September 1984 for DRG 209, we proposed to create a separate DRG for bilateral or multiple major joint procedures of the lower extremity.

We identified certain combinations of major joint procedures within DRG 209 that may both be performed during the same hospital stay. Each of these procedures requires the implantation of a separate prosthesis. We proposed that, if any two of the listed procedures are performed during the same hospital stay, they would be assigned to a new DRG that contains only those cases in which two major joint procedures, each requiring a separate prosthesis, were performed. Proposed DRG 471 (Bilateral or Multiple Major Joint Procedures of the Lower Extremity) would contain the

following codes: 8141, 8148, 8151, 8159, 8161, 8162, 8163, and 8164.

The original composition of DRG 209 would remain unchanged except that all cases indicating the performance of two major joint procedures during the same admission would be moved to the new DRG 471 representing multiple major joint procedure of the lower extremity.

*Comment:* The majority of commenters were supportive of our decision to revise DRG 209 and to create two DRGs—one for single joint procedures and one for multiple joint procedures. One commenter indicated that such a split set an unfortunate precedent for other DRGs and should not be implemented.

*Response:* As we noted in the proposed rule, we believe that there are sound clinical reasons for making the split and we are adopting our proposed policy. However, we will continue to monitor cases in these two DRGs to determine whether further action is necessary. In our opinion, our decision to split DRG 209 does not create a presumption that we would split other DRGs that include both single and multiple procedures. Any decision such as that would only be made after an examination of available data and a conclusion that it is appropriate and is based on sound medical reasons.

3. Kidney Transplants for Diabetic Patients

We learned that an anomaly in the ICD–9–CM coding conventions leads to the classification into DRG 468 of diabetic patients with end stage renal disease (ESRD) who receive kidney transplants. Because these cases are clearly more clinically coherent with the services described for DRG 302 (Kidney Transplant), we proposed to change the GROUPER program so that diabetic ESRD patients who receive kidney transplants would be properly classified into DRG 302. We note, also, that the range of resources embraced in DRG 302 is more appropriate for the procedures performed.

*Comment:* Commenters generally agreed with the result we proposed; however, one commenter suggested that the best method of achieving that result within the context of the DRG system would be to transfer those ICD–9–CM codes of diabetes with a manifestation of disease in a different organ system to the MDC corresponding to the organ system in which the disease manifestations occur.

*Response:* We agree and are revising the assignment of the following codes that are currently grouped to MDC 10, which includes the endocrine system. We are moving ICD–9–CM codes 25040 and 25041 for diabetes with renal manifestations to MDC 11, Diseases and Disorders of the Kidney and Urinary Tract, DRGs 331, 332, and 333. We are moving codes 25060 and 25061 for diabetes with neurologic manifestations to MDC 1, Diseases and Disorders of the Nervous System, DRGs 18 and 19. We are moving ICD–9–CM codes 25070 and 25071, diabetes with circulatory manifestations, to MDC 5, Diseases and Disorders of the Circulatory System, DRGs 130 and 131. All surgical procedures performed for patients with these diagnoses will group to the appropriate surgical DRGs within the MDC to which they have been assigned. We believe that these changes strengthen the logic of the GROUPER program and enhance the clinical coherence of the DRG system in the manner intended by its designers. In fact, we note that codes 25050 and 25051 for diabetes with ophthalmic manifestation were already grouped in MDC 2, Diseases and Disorders of the Eye.

*C. Recalibration of DRG Weights*

The DRG weights currently used in the prospective payment system are based on operating cost information from hospitals' 1981 cost reports as well as patient characteristics, diagnoses, and charge data from the 1981 Medicare provider analysis and review (MEDPAR) file. The MEDPAR file contains inpatient hospital billing records, coded to indicate principal diagnosis, presence or absence of a secondary diagnosis, and one surgical procedure, for a 20-percent sample of Medicare beneficiaries.

One of the basic issues in recalibration is the choice of a data base that allows us to construct relative DRG weights that most accurately reflect current relative resource use. We considered continuing to develop cost-based weights using cost data or a combination of cost and charge data. Alternatively, we considered basing the relative weights solely on hospital charge information, adjusted or unadjusted for capital costs, teaching, and wage costs. Extensive and recent charge information is available from the FY 1984 PATBILL data set. Effective October 1, 1983, PATBILL is designed to contain fully coded inpatient hospital bills for 100 percent of Part A beneficiaries (MEDPAR is a 20 percent sample).

In order to determine if DRG relative weights based on charges can accurately reflect the relative resource consumption across DRGs, we conducted a study that compared relative DRG weights computed based on 1981 costs with those computed on 1981 charges. A description of this study was presented in the NPRM (50 FR 24372). Based on the results of the study, we proposed to recalibrate the DRGs based on charge data.

The recalibrated DRG relative weights set forth in the NPRM were constructed from FY 1984 PATBILL data received by HCFA through December 1984, which was about 90 percent complete and thus contained about 90 percent of all Medicare discharges occurring in FY 1984, the first year of the prospective payment system. Approximately 40 percent of these discharges were paid under the prospective payment system, and 60 percent under State demonstration waivers and on a reasonable cost basis under the rate of increase limits. The FY 1984 PATBILL file which now includes nearly 11 million Medicare discharges, is about 95 percent complete. Because it will eventually include all inpatient hospital bills of Medicare beneficiaries, it is referred to henceforth as a 100 percent file or the universe of FY 1984 Medicare hospital bills.

The methodology used to calculate the DRG weights is as follows:

- All the claims were reclassified using the proposed revised GROUPER program.
- The average charge per DRG was calculated by summing the total charges for all cases in the DRG and dividing that amount by the number of cases classified in the DRG.
- We then eliminated statistical outliers using the same criterion as was used in computing the current weights. That is, all cases outside of 3.0 standard deviations from the mean of the log distribution of charges per case for each DRG were eliminated from the calculation of the average charge per DRG.
- The average charge for each DRG was then recomputed excluding the statistical outliers and divided by the national average charge per case for the average hospital to determine the weighting factor.
- No adjustments were made to the charges to remove capital-related and medical education costs. However, the charges were standardized for wage differences using the proposed survey-based wage index and for variations in teaching activity. The standardization for wage and teaching differences was done in essentially the same manner as it was in developing the initial set of DRG relative weights.
- Kidney acquisition costs continue to be paid on a reasonable cost basis, but, unlike other excluded costs, kidney acquisition costs are concentrated in a

single DRG (DRG 302, Kidney Transportation). For this reason, it was necessary to make an adjustment to prevent distortion of the relative weight for DRG 302. Kidney acquisition charges were subtracted from the total charges for each case in DRG 302 prior to computing the average charge for the DRG and prior to eliminating statistical outliers.

The weights developed according to the methodology described above were normalized so that the average case weight after recalibration is equal to the average case weight prior to recalibration.

When we established the current set of DRG relative weights, there were 109 DRGs that either contained no MEDPAR cases or had too few cases to provide a statistically reliable weighting factor. In order to construct a full set of relative weights, we supplemented the MEDPAR file with discharge records from Michigan and Maryland. The combined data sets were then used to calculate the weighting factors for the 109 low volume or empty DRGs.

By using the 1984 PATBILL data set, which represents substantially the entire universe of fully coded Medicare claims, rather than the MEDPAR file, which is a 20 percent sample of claims, the number of low volume and empty DRGs is reduced from 109 to 30 DRGs. In addition, sampling error is no longer a concern, which means that, in theory, a DRG weight could be constructed from a single case. In practice, however, we believe that some minimum number of cases is required to compute reasonable weights. In the NPRM, we proposed to use a minimum of 10 cases.

In computing weights for the 30 remaining low volume and empty DRGs, we decided to adjust the original weights of these DRGs by the percent change in the weight of the average case in the remaining DRGs. Therefore, we adjusted the original weights of the DRGs involved downward by approximately three percent. However, the renormalization of the entire set of relative weights involves adjusting the weights upward by approximately three percent. Therefore, the combined effect of these adjustments on the 30 low volume and empty DRGs was to leave their relative weights unchanged.

We received 46 pieces of correspondence on the DRG recalibration. Many of the commenters were pleased with our recalibration methodology. However, others voiced some concerns. Their comments and our responses are set forth below.

*Comment:* Commenters questioned the propriety of recalibrating the DRG relative weights using charge data from the PATBILL file instead of the cost data used in the current DRG relative weight computation. They believe that a decision to change the methodology should be made by Congress rather than the Secretary.

*Response:* We disagree with the commenters. We believe that the Secretary has the authority to make changes in the methodology for calculating the DRG relative weights. Section 1886(d)(4)(C) of the Act clearly directs the Secretary to recalibrate and adjust the DRG weighting factors at least every four years beginning with discharges occurring in FY 1986. In the absence of specific congressional action that instructs the Secretary to use a certain methodology and a specified set of data in accomplishing the recalibration that is required by law, it must be assumed that the Secretary has discretion within the law to select the data and develop the methodology to accomplish the task required.

As we stated in the proposed rule (50 FR 24372), the decision to use FY 1984 charge data for the recalibration was based on the following factors:

- Only if we use these data will be able to classify cases more accurately than was possible in constructing the current weights. The reason is that FY 1984 PATBILL data contain more detailed information on diagnoses, procedures, age, and discharge destination than does MEDPAR. Consequently, we will be able to use the same GROUPER program for recalibration as will be used for payment.
- Since FY 1984 PATBILL data are derived from nearly 100 percent of FY 1984 Medicare hospital discharges, the weights will be more reliable for all DRGs. Thus, we will be able to reduce significantly the number of low-volume and empty DRGs compared to what is possible using MEDPAR.
- FY 1984 PATBILL data are the most recent data, and therefore are more reflective to current treatment patterns than is MEDPAR.

We believe that these factors constitute a strong case in favor of using FY 1984 PATBILL data for the FY 1986 recalibration. In addition, we believe that this change in data allows us to be most responsive to the congressional mandate (section 1886(d)(4)(C) of the Act) that reclassification and recalibration reflect changes in treatment patterns, technology, and other factors that affect relative use of hospital resources.

*Comment:* One commenter was concerned that the recalibration methodology used charges and costs from two different periods. Citing the ProPAC study, the commenter stated that the Commission found a high correlation between 1981 costs and charges. The commenter doubted whether such high correlation exists between 1981 costs and 1984 charges.

*Response:* The commenter appears to be confused as to the methodology used in recalibrating the DRG weights. The weights were recalibrated entirely from the FY 1984 PATBILL file, which contains only charge data. No cost data were employed in the recalibration.

With respect to the comparison of 1981 costs and charges to which the commenters refer, both ProPAC's analysis and the analysis we performed compared the original cost-based DRG weights and a set of weights based on 1981 MEDPAR charges. Both comparisons arrived at very similar conclusions. There is a very high correlation between the 1981 cost-based weights and a set of charge-based weights drawn from the same discharge file for the same period. Our results and those of ProPAC agree entirely on these points. Moreover, with respect to the relationship between 1981 costs and 1984 charges, we also compared the recalibrated weights based on the 1984 PATBILL charges to the current weights based on 1981 costs, and again found a very high correlation between the two sets of weights. The Pearson correlation coefficient for the two sets of weights is .95.

*Comment:* One commenter objected to the use of charges in recalibrating the DRG relative weights because Congress mandated that payments to hospitals be made on a reasonable cost basis. The commenter argued that the use of charges makes it more difficult to determine whether payments approximate costs and, thus, whether we are violating the law.

*Response:* Under section 1886(d)(1)(A) of the Act (as added by Pub. L. 98-21), prospective payments determined under section 1886(d) of the Act for inpatient hospital services are to be computed notwithstanding the provisions of section 1814(b) of the Act. Therefore, the requirement to pay a prospective payment hospital its reasonable costs no longer applies. Current payment levels are derived from 1981 cost report data and rolled forward to later periods. However, under sections 1886(d)(4) (A) and (B) of the Act, we are obligated to construct a DRG classification system for classifying hospital discharges and for assigning an appropriate weighting factor that reflects the relative hospital resources consumed in treating each patient case assigned to a DRG. Thus, payment rates are no longer based on a

hospital's actual costs, but the relative weights do reflect relative hospital resource consumption as measured by bills for FY 1984 Medicare hospital discharges.

Section 1886(d)(4)(C) of the Act further directs the Secretary to adjust the discharge classification system and weights at least every four years beginning with discharges occurring in FY 1986 to reflect changes in treatment patterns, technology, and other factors that may change the relative use of hospital resources. By using charge data to recalibrate the DRG relative weights, we believe that we have maintained an appropriate index of relative hospital resources use across DRGs while, at the same time, complying with the legislative mandate to recalibrate the weights taking into account changes in treatment patterns, technology, and other factors affecting relative resources consumption.

*Comment:* One commenter argued that the high correlation reported in the proposed rule between DRG relative weights based on 1981 cost data and weights based on charge data for the same period is to be expected because of the use of charges in the original data base used to determine ancillary costs. To the extent that the cost to charge ratios have remained constant over the intervening years, the commenter believes that one could expect the same degree of correlation to persist. The commenter seemed to draw the conclusion that the PATBILL data used to recalibrate the DRG weights ". . . does not validate the weighing system . . . ." The commenter stated that a better system for measuring resource consumption must be utilized in order to validate the present system.

*Response:* The commenter appears to have misunderstood the reason for using charge data to recalibrate the DRG weights. We are using the charge-based weights because the charge data provided on the PATBILL is more detailed and current than the cost data available to us. Therefore, we consider the charge-based weights more valid than a comparable set of weights based on the available cost data. However, the charge-based weights are not intended to validate the cost based weights.

The fact that there is a high correlation between the two sets of weights permits us to use the 1984 charge-based weights with reasonable confidence that they reflect the relative resource use across DRGs as accurately as a set of cost-based weights do. As explained above, the use of the charge data in recalibrating the DRG weights affords us the advantages of using what we consider to be superior data than would be available were we to recalibrate the weights using cost data.

*Comment:* We received a comment inquiring whether the proposed revisions make the revised DRGs "better behaved" in a statistical sense and whether, for example, coefficients of variation are reduced.

*Response:* In general, the proposed grouper changes and reconfigurations of the DRGs were made on clinical rather than statistical grounds. Since the proposed changes do not alter the basic framework of the DRGs, we did not perform statistical tests such as those conducted by Yale University in establishing the DRGs.

*Comment:* We received a comment that we should recalibrate the DRG relative weights using only data for discharges paid under the prospective payment system to avoid distortions due to the previous cost-based payment system.

*Response:* Although in principle we agree with this comment, we think that the disadvantages of recalibrating using only the prospective payment system bills outweigh the advantages. All hospitals were required to begin coding 100 percent of their cases on the Uniform Institutional Provider Billing Form (UB–82) effective October 1, 1983. Since only 40 percent of the FY 1984 bills were paid under the prospective payment system, recalibrating using only the prospective payment system bills would significantly reduce the number of cases used to determine the relative weights. It also increases the number of low-volume DRGs. In addition, the FY 1984 prospective payment system cases are not representative of a full year's set of the prospective payment system cases because hospitals came on the prospective payment system at the start of their accounting year. For example, the hospital accounting year for many large teaching hospitals begins on July 1, so that their prospective payment system cases were limited to the fourth quarter of FY 1984. This phenomenon might also create seasonal effects that would not occur if data for a full year are used. Finally, differences between the prospective payment system and other cases may be lessened by the fact the law in effect before the prospective payment system was implemented also provided incentives for increased cost consciousness.

*Comment:* We received several comments about the use of charge data to recalibrate the DRG relative weights. Many commenters noted the high correlation between the cost and charge weights constructed from the 1981 data, but wondered about differences that might not be reflected by a measure as the correlation coefficient. A few commenters specifically questioned our statement that the two sets of weights differed by no more than five percent for most DRGs.

*Response:* The results reported in the proposed rule were based on an analysis of the 358 DRGs for which enough 1981 MEDPAR cases existed to construct reliable weights.[1] This study found a high degree of correspondence between the relative weights constructed according to our original methodology and those based solely on charge data. Both the Pearson and Spearman correlation coefficients were greater than .99. Further, the two sets of weights differed by less than 5 percent for 296 of the 358 DRGs, and these 296 DRGs accounted for 89.5 percent of the total cases. ProPAC's independent analysis of the 1981 MEDPAR data confirmed these results. ProPAC's cost and charge weights differed by less than 5 percent for 328 of the 358 DRGs (96.1 percent of the total cases). The greater similarity of ProPAC's cost and charge weights is attributable to the fact that they standardized the data for differences in indirect medical education costs; the internal HCFA study did not.

*Comment:* We received comments about two potential problems with our proposed use of charge data to recalibrate the DRG relative weights. Specifically identified were the common practice of setting different cost-to-charge ratios for different departments within a hospital and the lack of an adjustment for capital costs. Examples given included the effect on the charge weights of "undercharging" for intensive care and for expensive prostheses.

*Response:* Based on our study of the 1981 MEDPAR data, we concluded that neither of these factors creates major differences between the original set of weights and those based solely on charge data. The high degree of overall similarity between the cost and charge weights indicated that the effects of these factors were relatively small. The chief systematic difference between the two sets of weights was that the charge weights were slightly less compressed than the cost weights. That is, high-weight DRGs (low-weight DRGs) tend to have higher (lower) charge weights than cost weights.

[1] Philip Cotterill, Joel Bobula, and Rose Connerton, "A Comparison of Alternative DRG Relative Weights for the Medicare Prospective Payment System," HCFA Internal Working Paper, February 1985, available upon request.

The HCFA study recognized the issue raised in the comments regarding the effects of differences in cost-to-charge ratios among departments within the hospital. For example, if most hospitals cross-subsidize in the same manner, then DRGs with high proportions of cost in "undercharged" services might have lower charge weights than cost weights. Since "undercharged" services are typically thought to be relatively high cost services, cross-subsidization might be expected especially to affect high-weight DRGs with above average proportions of "undercharged" costs.

The HCFA study investigated this issue for the case of special care (which includes intensive care). The study found that among the 358 DRGs studied, there were 84 that had a relative weight greater than 1.0 and an above average proportion of special care costs (greater than 6 percent of total cost). Contrary to the hypothesized effect, the charge weights exceeded the cost weights for 77 of these 84 DRGs. The reason for this result is that there is a positive correlation between the proportions of cost in special care and in the ancillary categories with lower cost-to-charge ratios. In other words, a high proportion of special care costs does not generally compress the charge weight for a DRG because relatively high utilization of special care is accompanied by relatively high utilization of ancillaries, such as x-ray and laboratory services.

One commenter also mentioned DRGs 39 (lens procedures) and 209 (major joint procedures) as examples where "undercharging" for prostheses might be expected to yield charge weights that are lower than cost weights. A comparison of 1981 cost and charge weights from the HCFA study cited above did not yield this result. For both of these DRGs, the charge weight was about one percent higher than the cost weight.

Both the cases of special care and expensive prostheses suggest that the effects of cross-subsidization are more complicated than indicated by the reasoning set forth in the comments on this topic. Indeed, the effects may in many cases be largely offsetting.

*Comment:* One commenter stated that "HCFA readily admits problems in comparing the set of cost-based weights with the charge-based weights," and quotes our statement from the study of 1981 MEDPAR data that "Charge-based weights were not renormalized to accommodate 'external data' for the remaining 109 DRGs."

*Response:* Omission of the 109 "low volume" DRGs from the comparison of 1981 cost and charge weights does not significantly limit the comparisons that can be made between the two sets of weights. The point of the study was to compare weights constructed from Medicare data using alternative methods. The 109 DRGs omitted from the study accounted for less than 0.3 percent of Medicare inpatient hospital discharges in 1981. The sentence quoted in the comment was not indicative of a problem, but rather merely stated that the method of constructing the weights was consistent with the fact that the study was restricted to the 358 DRGs for which there were enough cases in the MEDPAR data to construct a reliable relative weight.

*Comment:* We received one comment that basing new weights on 1984 data suffers from the problem that claims processed and recorded by the fiscal intermediaries for that year are far from complete, and that the more complex and extraordinary cases may not be included in the recalibration process. The commenter also mentions that certain States may have larger backlogs than others and are, therefore, not fully represented in the recalibration data base.

*Response:* The data base used for recalibrating the relative weights for the proposed notice included all short-stay hospital bills for FY 1984 received as of December 28, 1984. The total number of bills used in the preliminary recalibration effort was 10.2 million, which represented approximately 90 percent of expected FY 1984 bills. The data base used for recalibrating the relative weights for this final rule included all short-stay bills for FY 1984 received through April 26, 1985. The total number of bills used in the final recalibration effort was 10.8 million, approximately 95 percent of all expected FY 1984 bills.

A comparison of average charges and lengths of stay between the preliminary data sets indicates that the earlier file may not have included all of the most costly and longer length of stay cases. In addition, some States were somewhat slower than others in bill processing, relative to the experience of prior years. However, the final recalibration data set, which included 95 percent of the expected total number of bills, conformed more closely with past experience. As a result, we believe that the concerns raised in this comment have been adequately addressed by the use of the final recalibration data set.

*Comment:* A commenter believes that it is inappropriate to adjust the data for the indirect costs of medical education when calculating the DRG relative weights. The commenter also noted that teaching hospitals account for a disproportionate number of cases in selected DRGs, so that the adjustment for indirect medical education costs will disproportionately reduce the relative weights for these DRGs. The commenter further noted that adjusting the relative weights for indirect medical education costs "alters the need" for an indirect medical education adjustment to payments and may redistribute payments among hospitals. The commenter concluded that it is critical that HCFA avoid building biases into the pricing system through the methods used to construct the relative weights and to set prices.

*Response:* We certainly agree that biases in the pricing system should be avoided, but we disagree that it is inappropriate to adjust the data for indirect medical education costs in calculating the relative weights. Our reasoning is precisely that noted in the comment: Teaching hospitals account for a disproportionate number of cases in selected DRGs.

Since the prospective payment system makes an additional payment for indirect medical education costs, the relative weights should be standardized to remove these costs in order to avoid overcompensating teaching hospitals for those DRGs. Further, we wish to note that the payment adjustment is twice that used in standardizing the data used to derive the relative weights. We believe that the appropriate policy would be to reduce the adjustment factor used in computing the additional payments to the same level as that used in standardizing the relative weights, not to alter the latter adjustment. The consistent treatment of indirect medical education costs in computing the relative weights and in adjusting payments would achieve the objective of avoiding biases in the pricing system.

*Comment:* A commenter was conserned that, by including transfer cases in the calculation of the relative weights, we might be inappropriately reducing the relative weights of DRGs in which there are significant proportions of transfer cases.

*Response:* This commenter assumes that the charges for transfer cases are lower than charges for the average case in a DRG. Our data show that this assumption is not correct for many DRGs. To test the effect of including transfers in the calculation of the relative weights, we computed mean charges for each DRG, both with and without the transfer cases. We then conducted statistical tests to determine whether these two means differed significantly at the .05 confidence level (that is, there is only a .05 probability that the observed difference in the

means would occur if the two sets of cases came from the same underlying population). The results indicate that transfers have a statistically significant effect on the mean charges of only 16 DRGs. For 13 of the 16 DRGs, inclusion of transfer cases tends to increase the mean charges. However, for three DRGs, the mean charges are reduced by the inclusion of the transfer cases.

Since the inclusion of transfer cases raises the mean charges for some DRGs and lowers them for others, and because these effects are limited to such a small number of DRGs, we decided not to revise the method we used to recalibrate the relative weights. During FY 1986, we will be studying the entire issue of transfers and the appropriate payment for these cases. This study may reveal other ways of handling transfer cases in future recalibrations.

*Comment:* We received several comments on the topic of normalization of the relative weights; that is, the adjustment that was made to ensure that recalibration did not affect the aggregate level of payments. Some of these comments reflected confusion over the nature of this adjustment. One commenter referred to this adjustment as "restandardization," a term we use only for adjustments that influence relative payments among different hospitals. A second commenter misunderstood our normalization of the relative weights compared to the method recommended by ProPAC. Finally, several commenters requested evidence that our normalization would in fact have no effect on aggregate payments in FY 1986.

*Response:* In the regulatory impact analysis section of the proposed rule (Appendix A), we presented our estimate of the impact of recalibration on aggregate payments to all hospitals. Column one of the table at 50 FR 24438 showed a 0.11 percent increase in total payments due to recalibration. This estimate has been updated using more recent data than was available at the time the proposed rule was published and appears in the appendix to this document. In both cases, these estimates support our belief that recalibration of the relative weights was carried out in a manner that does not materially affect the aggregate level of payments to all hospitals in FY 1986.

Regarding the difference between our method of normalizing the relative weights and the method recommended by ProPAC, we note that the two methods are equivalent, except that we did not follow Pro PAC's recommendation that the weights be adjusted for any demonstrable changes in reported case mix occurring during FY 1985. ProPAC made this recommendation to "prevent these coding changes from being built into future prospective payment system payments." We have not penalized hospitals, as the commenter argues, by not adopting this ProPAC recommendation. We do not have sufficient data for FY 1985 to enable us to make this adjustment.

*Comment:* We received two comments about our use of the 1984 PATBILL data to determine the relative weight for a DRG as long as there were at least 10 cases for the DRG. One of these comments was quite critical, stating that the threshold of 10 cases is "without merit, unsupported and completely unjustified." The other comment did not oppose the proposed threshold but expressed concern that the affected DRGs be monitored to determine the appropriateness of their relative weights.

*Response:* The use of 1984 PATBILL data for recalibration permitted us to reduce the number of DRGs whose relative weight had to be based on non-Medicare data because the PATBILL data contains 100 percent of Medicare inpatient hospital discharges. (The MEDPAR data, in contrast, is only a 20 percent sample.) The use of the 100 percent data also changed the basis for deciding whether enough Medicare cases were available to establish a reliable relative weight for a DRG. Specifically, since the data are not from a sample but now represent the universe of Medicare beneficiaries' hospital experience, there is no explicit statistical criterion to be applied. As a result, we elected to set a relatively low threshold in order to maximize our use of Medicare data in determining the relative weights.

Our decision was based on the premise that relative weights based on Medicare data will yield more appropriate relative payment rates for Medicare beneficiaries than will some external data source. The aged or disabled nature of Medicare beneficiaries may make their medical care needs different from those of other population groups. We believe that a comparison of the original and proposed weights for the 79 affected DRGs supports our approach. In general, the relative weights of these DRGs increased as a result of replacing non-Medicare data with Medicare data. This result is explained by the fact that a majority of these DRGs are for persons under age 18 or for obstetrical patients; and Medicare beneficiaries in these groups are almost exclusively end stage renal disease patients or disabled beneficiaries. These groups clearly have special needs that may account for their relatively resource intensive hospital care.

There are fewer than 50 DRGs with fewer than 50 cases each. In total, these DRGs account for fewer than 500 cases out of the more than 10 million Medicare cases in FY 1984. Given the very small number of cases affected by the choice of a particular threshold, we do not believe that the affected DRGs require special monitoring.

*Comment:* We received inquiries during the comment period concerning the weights assigned to DRGs 385, 386, 389, 390, and 391 (which consist of diagnoses associated with newborns) and the fact that these DRGs are no longer low-volume DRGs. The commenters state that, with the exception of certain diagnoses codes for congenital anomalies not elsewhere classified or not otherwise specified (7597, 7598, and 7599), which could theoretically apply to adults and children beyond infancy, all other diagnoses resulting in assignment to MDC 15, Newborns and Other Neonates with Conditions Originating in the Perinatal Period (that is DRGs 385 through 391), are specific to infants. Moreover, because Medicare entitlement for infants is statutorily limited to those infants suffering from end-stage renal disease, an extremely small population group, and because few adults should have principal diagnoses described by the above-mentioned codes, the commenters believe that there should be virtually no Medicare cases in this MDC. Therefore, the commenters do not understand why these DRGs were not designated as low-volume in Table 5 of the NPRM.

*Response:* As a result of these inquiries and our continuing analysis, we have determined that DRGs 385, 386, 389, 390, and 391 should continue to be treated as low-volume DRGs. In reviewing the diagnostic information associated with these cases in the PATBILL file used for recalibration, we have found that certain ICD-9-CM codes that are specific to infants, such as unspecified fetal and neonatal jaundice (code 7746), are being used for adult patients. It appears that these codes are being incorrectly assigned to similar conditions occurring in adult patients, and we are continuing to review these cases in order to evaluate the propriety of the coding.

In light of our concerns about the potentially faulty coding of these cases and the fact that there should be few, if any, Medicare cases assigned to the DRGs in MDC 15, we have decided to continue to treat DRGs 385, 386, 389, 390,

and 391 as low-volume DRGs. Accordingly, their weights as shown in Table 5 of this final rule are the same as those currently in use (see the proposed rule (50 FR 24373) for a full explanation of the assignment of weights to low-volume or empty DRG categories). Since there should be few Medicare cases appropriately grouped to this MDC, maintaining the weights currently in effect should have a negligible impact, if any, on a particular hospital's Medicare payment. We note that DRGs 387 and 388 were already classified as low-volume DRGs in the proposed rule, having not met the 10-case threshold that was set forth in that document. Therefore, there are now 35 low-volume or empty DRGs rather than 30, as was stated in the NPRM.

In addition to reviewing the particulars of the PATBILL cases that were grouped into MDC 15, we are also examining the possibility of modifying the DRG classification or the GROUPER in order to distinguish newborns from adult or nonnewborn pediatric patients with certain congenital anomalies. In keeping with our provisions on changes to the DRG classifications and the GROUPER, described in this section of the preamble, these changes would be subject to notice and comment. Also, to assure that cases assigned to MDC 15 are appropriately coded, we may institute age screens in the Medicare code editor.

*Comment:* Many of the commenters argued that they were prevented from submitting meaningful comments on many aspects of the proposed rule, including the DRG recalibration and the FY 1986 rates, because we did not release timely the date necessary for a thorough evaluation of these proposals. In particular, many commenters believe that our failure to disclose the PATBILL file prevented verification of the accuracy of the proposed recalibrated DRG weights, as well as a determination of the impact of the recalibration on specific hospitals. In addition, these commenters objected to the 30-day comment period allowed for the proposed rule because they claim that 30 days is not enough time to evaluate the proposals, especially since the data requested by these commenters were not released until July 2.

*Response:* As we indicated earlier, we understand the concerns expressed by the commenters regarding the length of the comment period, as well as concerns about public access to data that were used in determining the various weights, factors, and rates set forth in the proposed rule. However, because of the voluminous amount of data associated with the computation of the weights, factors, and rates and because of the limited interest that these data would have for the majority of readers, we do not as a matter of policy publish this material as an adjunct to our proposed rules. We believe that the methodology used to recalibrate the DRG weights was described in sufficient detail to allow informed public comment. In this regard, we believe we have complied with the Administrative Procedure Act (5 U.S.C. 553).

All disclosable data and information are available to the public upon request. While we do not guarantee that requested information will be furnished in the format desired by the requester, we have responded and will continue to respond promptly to all requests for material and provide all the available data to assist the hospital industry and other parties interested in the evaluation of our proposals for the prospective payment system.

In response to the specific request for the FY 1984 PATBILL data used in recalibrating the DRG weights, we made these data available at a July 2, 1985 meeting that was held specifically to present interested parties with a description of the data and methodology used to develop the proposed FY 1986 prospective payment rates. HCFA technical staff were available at the meeting to answer any questions concerning our methodology. While public meetings of this type may be helpful in the exchange of information and recommendations on regulatory matters, we still view the formal rulemaking process as the principal avenue for announcing changes in the Medicare program. The proposed rule was the formal instrument for disseminating our proposed policy concerning the payment rates, DRG weights, and other relevant factors for FY 1986.

As a part of the rulemaking process, we recognize our obligation to provide a reasonable period of time for interested parties to comment and make recommendations on our proposed policies. Yet, we do not believe that the fact that the PATBALL file was not disclosed at the time we published the proposed rule is a sufficiently strong argument to have extended the comment period and risk missing the September 1 publication deadline for the final rule mandated by section 1886(d)(6) of the Act. The PATBILL file is not necessary to comment on the significant issues related to the proposed methodology but is primarily useful only for the relatively minor purpose of checking the accuracy of our computations. We have not received any indication that we made computational errors. Section 1886(e)(5)(B) of the Act reiterates the requirement to publish the final rule timely for FY 1986. We believe that a 30-day comment period was justified considering our obligation to publish the new rates timely.

We would like to point out that in addition to disclosing the FY 1984 PATBILL file, we have readily provided, upon request, the hospital cost report file and the wage index raw data file. We believe that we have cooperated fully in furnishing information to the public, and we will continue to cooperate fully with proper requests for information.

*Comment:* One commenter recommended that we recalibrate the DRG relative weights annually.

*Response:* Section 1886(d)(4)(C) of the Act requires the Secretary to reclassify and recalibrate the DRG weighting factors for discharges occurring in FY 1986 and at least every four years thereafter. Under section 1886(d)(4)(D) of the Act, ProPAC is required to advise the Secretary on any adjustment of the DRG weights based on its evaluation of scientific evidence with respect to new practices, including the use of new technologies and treatment modalities.

Although the medical treatment of patients is evolving at a rapid pace, these changes do not automatically translate themselves into changes of the DRG weights. For example, changes in medical technology or practice patterns may result in the substitution of low risk procedures for high risk procedures, or procedure modifications within the same DRG may offset one another leaving resource consumption virtually unchanged. We believe that treatment changes in and of themselves do not necessarily alter resource consumption levels and often have no significant effect on the relative weights.

It is our opinion that recalibration should be performed periodically, as required by law, and when there is an indication that changes in practice patterns, technologies, or treatment modalities have significantly altered relative resource consumption patterns. We will also consider changes in the GROUPER Program that could alter relative consumption among DRGs. As a part of the process for considering when to recalibrate, we will review ProPAC's recommendations as well as comments from all interested parties. In essence, except for statutory requirements, we believe that a decision to recalibrate should be made when the accumulated evidence indicates a need for recalibration.

*Comment:* One commenter believes that the entire procedure currently in place for paying for discharges that include an unrelated operating room procedure (currently classified into DRG 468) should be reexamined. The commenter states that originally DRG 468 was intended to be used for cases that were ". . . truly different types of cases or were coding problems . . ." that were to be reviewed and reassigned to the DRG providing the fairest relative weight as indicated by the clinical circumstances. The commenter is concerned that the current method of payment for cases assigned to DRG 468 makes no sense clinically and can result in significant overpayments because of the high weight of DRG 468.

In lieu of the current procedure, the commenter proposed a procedure in which a Peer Review Organization (PRO) would review all DRG 468 cases to determine the necessity for admission, procedure, and length of stay. Payment for the discharge would be based on the average per diem amount of DRG 468 using the same procedure we currently use for day outliers. The commenter believes that this procedure would also solve the problem of patients who are assigned to DRG 468 because of complications that result from outpatient surgical procedures.

*Response:* We agree with the commenter that the present payment system may not provide the most appropriate payment amount for some cases that are assigned to DRG 468. Currently, payment for cases in DRG 468 is determined the same way payments for the other 467 DRGs are computed; however, DRG 468 is intended to represent a category of cases that cannot be logically assigned to any other DRG. Operationally, we have defined these cases as those in which all of the surgical procedures performed are unrelated to the patient's principal diagnosis. We have computed the relative weight of DRG 468 to reflect the relative resources consumed in the treatment of cases that are assigned to this DRG.

While the present system and method of payment may not be totally appropriate for the type of cases assigned to DRG 468, we believe that we are using the best method for determining this payment given the design of the prospective payment system. Currently, 100 percent of the cases assigned to DRG 468 are reviewed by a PRO for admission review and coding accuracy, and cases that are inappropriately coded are changed. This review process has served to substantially reduce the number of cases finally assigned to and paid under DRG 468.

In addition, as discussed in section II.A. of this preamble, we have revised the GROUPER program to include additional surgical procedures that could be associated with a particular MDC so that a discharge that includes one of these procedures will be assigned to the appropriate DRG rather than DRG 468. For example, procedure 7679 (open reduction of facial fracture, not elsewhere classified), commonly associated with principal diagnoses in MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissues), can now also be associated with principal diagnoses in MDC 2 (Diseases and Disorders of the Eye). Therefore, cases including a facial bone fracture in conjunction with a principal diagnosis of a disease or disorder of the eye will no longer be grouped into DRG 468.

Although we believe that these changes in the GROUPER program will further reduce the number of cases that could potentially be assigned to DRG 468, we recognize that these modifications do not address other problems of DRG assignment such as the one described by the commenter involving complications resulting from outpatient surgery. This issue requires further study.

*Comment:* One commenter objected to the recalibration methodology on the grounds that the DRG classification scheme fails to recognize and compensate for the severity of a patient's illness or condition within any given DRG. Citing a recent study on severity of illness,[2] the commenter argued that the current DRG-based payment system is inherently inequitable because it fails to account for the severity of illness differences among cases within DRGs.

*Response:* Without discussing here the specifics of the study cited by the commenter, the degree to which the current prospective payment system is creating distortions in the selection of patients for inpatient treatment is far from clear. However, the possibility of the failure of the DRG system to distinguish methodically among and account for resource use by severely ill patients is of deep concern to us. We clearly recognize our responsibility for constructing an economically neutral set of relative weights that will not systematically advantage hospitals that treat the relatively simple cases within a given DRG while denying treatment to other more severely ill patients because of the lack of appropriate economic incentives.

As a result of this concern for payment equity, we are anticipating conducting a research program to collect data and study the effects of severity of illness on hospital prospective payments. The study will also examine and test various competing measures of illness severity to determine which system or combination of systems affords us the best opportunity for improving the payment system with minimal disruption to the present system and minimal added implementation cost. If it is determined that severity of illness is a significant factor in resource use that is unaccounted for by the adjustments already made by the DRG system, we would certainly seek to recognize it appropriately through an equitable redistribution of payments.

*Comment:* One commenter suggested that because of the degree of variation between the previous set of DRG weights and the proposed set, the recalibrated weights should be phased in over a three-year period through a blending of the old and new weights. Based on an analysis of the recalibrated weights, the commenter believes that hospital revenues will be adversely affected. By having the new weights phased-in, the commenter hopes that the expected negative impact of the recalibration would be ameliorated.

*Response:* We disagree with the commenter's recommendation to phase in the new weights through a blending of the old and new weights for several reasons. First, by blending the two sets of weights, we perpetuate the use of outdated data in the payment formula. We believe that these data no longer reflect the current resource consumption patterns in either an absolute or relative sense. Nor do the previous weights reflect changes in practice patterns or technology that have occurred since 1981. We believe that retaining the old weights in the payment system through some form of blending would retain outdated data in the recalibrated weights, thus producing distortions in the payment amounts and diluting the effects of the recalibration.

In addition, if we recalibrate the weights annually by blending the previous year's weights with the recalibrated weights, we could create a situation in which old data were perpetually incorporated into the payment formula. We believe that the intent of Congress in including section

[2] Susan D. Horn, et al.: "Interhospital Differences in Severity of Illness: Problems for Prospective Payment Based on Diagnoses-Related Groups (DRGs), *New England Journal of Medicine*, Vo. 313, No. 1, 7/4/85, pp. 20–24.

1886(d)(4)(C) in the Act was to permit periodic updating of the relative weights to reflect the most current resource consumption patterns based on the most current data. Blended weights that are constructed using combined old and new data would defeat the purpose of this statutory requirement.

A further objection to the commenter's suggestion is that it only addresses the negative impact of recalibration on hospital revenues while ignoring any positive effects. Blending the weights that were in effect for FY 1985 with the recalibrated weights would only benefit those hospitals with discharges predominantly occurring in those DRGs whose recalibrated weights are lower than the FY 1985 weights. However, hospitals with discharges concentrated in those DRGs whose weights are increased by the recalibration would be disadvantaged if we adopted a blending recommendation.

In section J of the impact analysis, in the appendix to this final rule, we indicate that, in the aggregate, recalibration has an insignificant effect on hospital revenues. This lends support to our belief that the method used in recalibrating the weights, by itself, is neutral with respect to total hospital payments. (In fact, as indicated earlier in this section of the preamble, the recalibrated weights were normalized so that the average case weight using the recalibrated weights equals the average case weight using the weights in effect for FY 1985. Without this normalization, the average case weight using the recalibrated weights would have been lower.) It is the distribution of cases across hospitals that produces fluctuations in hospital revenues rather than the recalibration of the weights.

We point out that a decrease in a particular DRG's relative weight because of recalibration indicates that in FY 1985 we may have overpaid hospitals for discharges assigned to that DRG. Conversely, an increase in a particular DRG's weight indicates that hospitals were probably underpaid for discharges in that DRG for FY 1985. Blending the weights effective in FY 1985 and the recalibrated weights would merely maintain these inequities.

Finally, if the recalibrated weights represent the best available and most current measure of relative resource use, blending weights will potentially aggravate the cash flow problems of hospitals that have been experiencing losses because the current weights are based on out-of-date data. In effect, implementing blended weights would only create different categories of hospitals that are advantaged or disadvantaged; blending would not result in a technically superior set of weights. It is possible that an individual hospital could receive increased payments because of the recalibrated weights, just as another hospital may experience a decrease in payments.

*D. Procedures for Making Changes During the Year*

We stated in the proposed rule that we plan to make most of the changes we would want to make in the GROUPER program or the DRG classification system at the same time we publish the annual prospective payment rate notices required by § 412.8(b) in order to make the system as predictable as possible during the year. However, we believe that this interest may occasionally be overridden by the need to make certain changes on a more current basis to—

- Account for new items and procedures that become covered under Medicare during the course of the year; and
- Correct omissions or inequities that have a potentially substantial adverse impact on beneficiaries or a significant and unwarranted fiscal impact on the system.

We proposed to add a new § 412.10 to the regulations that would allow us to make these types of changes to the DRG classification system during the Federal fiscal year. We stated that these changes would be announced through HCFA's administrative issuance system. We also proposed that changes made under this provision of the regulations would be published for public comment in the next annual notice of prospective payment rates.

With one exception, which is described below, we did not made any significant DRG classification changes until now because we had not stated in previous documents that we would make changes outside of the overall recalibration and reclassification effort prescribed by section 1886(d)(4)(C) of the Act. However, we believe than when we identify cases that have a major fiscal impact, it is appropriate to deal with them as soon as possible after they are discovered so that appropriate levels of payment can be made.

In addition, Congress provided the Secretary with authority to reclassify services and procedures within the DRG system to take into account changes in medical technology and treatment patterns. Accordingly, section 1886(d)(4)(C) of the Act requires that the Secretary adjust the DRG classification and weighting factors effective for discharges occurring in FY 1986 and at least every four fiscal years thereafter. These adjustments are made to reflect changes in resource consumption, treatment patterns, technology, and any other factors that may change the relative use of hospital resources. The intention of Congress was that we would make changes as often as needed to achieve the objectives of the prospective payment system, including the need to keep current with developments in the areas of coverage and medical technology.

We believe, however, that our decision to make limited changes in this way is consistent with the view of Congress, which exempted the establishment, methodology and weighting of DRGs from judicial review because of their complexity and ". . . the necessity of maintaining a workable payment system." (H.R. Rep. 25, 98th Cong., 1st Sess. 143 (1983).) In order to assure adequate public notice of these changes and an opportunity to comment on the coverage additions, we plan to publish an annual notice of classification changes for public comment, as described below.

The one change we have made already was to incorporate into the classification system two types of lithotripsy procedures so that Medicare beneficiaries could benefit from the procedures and hospitals could be paid for them once Medicare coverage was extended. In the case of these procedures, it was possible to incorporate them into the system by identifying the appropriate DRG and assigning an appropriate code. We included in the proposed rule (50 FR 24374) a full discussion of the process by which we determined how to make the lithotripsy change as an example of the approach we plan to take with interim changes. That change was subject to comment in the proposed rule along with the proposed procedures.

If the GROUPER program is not capable of assigning cases to the DRG that we have found to be appropriate, the Medicare Code Editor or manual claims review may be considered for use in the interim until GROUPER changes can be made.

*Comment:* Virtually all those who commented were disturbed by our proposal to make interim changes during the year by means of our administrative issuances system with all changes being subjected to public comment at the time of the first annual prospective payment update notice published after the changes were made. They all indicated the need for the opportunity for public comment before any changes are implemented. ProPAC, in its comment, pointed out that the law requires that we consult with it before making any changes.

*Response:* We recognize the basis for the concerns that were expressed by these commenters and have modified the approach we plan to take. We note, however, that the comments generally failed to take account of two important factors that affect the selection of procedures to use. First, as we noted several times in the proposed rule, we plan to implement very few changes other than during the annual notice of classification changes. We would make interim changes only to provide coverage of new items or services or to correct serious omissions or inequities. Our examples showed the type of rare situations of which we planned to take account.

The use of the full notice and comment process to make such interim changes would largely defeat the purpose of making them since that process can typically take from six to nine months to complete. We have, therefore, decided to establish two separate mechanisms for making interim changes apart from the annual notice of classification changes. Changes that are of the greatest importance are those that involve additions of coverage, and we still plan to implement these decisions by means of administrative issuances, since we do not believe that extensions of coverage should be delayed until the payment system can accommodate these changes in the most appropriate manner. Changes that involve omissions or inequities would be made formally, with a prospective effective date, through a **Federal Register** final notice with comment period, so that comments can be made by the public. Before either type of change takes effect, we will consider ProPac's comments. In order to assure adequate public notice and opportunity for comment, we will also include both types of changes in the annual classification notice discussed below. The coverage changes will be subject to formal comment; changes involving omissions or inequities already published in a **Federal Register** notice with comment period will be republished for purposes of providing complete information.

*Comment:* A number of commenters stated that any changes during the year would be disruptive because they would require modifications in hospital versions of the GROUPER program. They indicated that they needed a stable grouping and pricing mechanism during the year to conduct proper financial planning. They further suggested that all GROUPER changes (that is, classification changes) should be made before the annual updating process so that it would be available to them for analysis and for use in evaluating other changes. Some commenters suggested that software should be made available from Medicare without cost to the hospital.

*Response:* In part, we believe that the concern about disruptions is based on the mistaken belief that changes would be relatively numerous and would require reprogramming of software for grouping programs. We expect that these changes will be very infrequent and that hospitals will be able to make them manually until the next annual update of the GROUPER program. We do recognize that it would be more convenient for us, for ProPAC, and for the provider community to have annual GROUPER revisions completed before the annual prospective payment update notice and we have therefore decided to propose these changes separately. We will analyze all proposed changes in the classification system and the GROUPER program on a continuing basis and publish proposed changes in a separate notice early in the calendar year. (As noted above, this notice will also include for public comment all the interim changes made through administrative issuances during the previous year to accommodate coverage changes. Changes previously published that year in the **Federal Register** to correct omission and inequity problems will also be published as a matter of information but would not be subject to comment.) We will then analyze the comments and publish a final notice before or concurrently with the annual prospective payment update proposal. The changes will be effective beginning on the next October 1, at the same as the annual update on the prospective payment rates. Thus, both HCFA and the provider community will be able to evaluate the updating proposals by use of an updated GROUPER software package. Because it is not necessary for a provider to purchase such software in order to submit claims for Medicare payment, however, we did not accept the recommendations that Medicare provide the software without charge.

Although we are planning to publish future classification changes as discussed above, we have included in this regulation the classification changes proposed in the June 10 proposed rule as modified by the comments and suggestions we have received. We have also included some additional changes that we believe follow the principles discussed in the proposed rule or are similar to them. Future changes of this nature will, however, be published separately.

Some commenters will note that this preamble does not address certain GROUPER and classification issues they raised. This is because the suggestions either required indepth statistical analysis or a change in the ICD-9-CM coding system. All comments that fit these categories will be analyzed and reviewed during the next several months and actions on them will be published early in 1986.

In keeping with our commitment to review GROUPER and classification changes on an ongoing basis, any proposed GROUPER or classification changes should be made in writing. They should state succinctly the issue of concern. Any rationale for the change or supporting documentation should be included in the proposal and sent to the following address:

Health Care Financing Administration, Department of Health and Human Services, GROUPER Changes, P.O. Box 26681, Baltimore, Maryland 21207

An acknowledgment of receipt of the proposal will be sent.

*Comment:* We received several comments concerning the assignment of extracorporeal shock wave lithotripsy to the medical DRGs 323 and 324. The commenters believe that the resources consumed in the provision of this procedure are much greater than the resource consumption reflected in the weights for these two DRGs. They suggest that either the procedure be classified into DRGs 304 and 305 (surgical DRGs) or that a separate DRG be created.

*Response:* We appreciate the concern expressed by the commenters. However, based on the data available, we believe that DRGs 323 and 324 are the appropriate clinical classification for extracorporeal shock wave lithotripsy and that this classification will result in adequate reimbursement for efficiently operated, fully utilized lithotripsy centers.

We assigned extracorporeal shock wave lithotripsy to a medical DRG primarily because it is a noninvasive procedure and the clinical course of patients treated with lithotripsy, particularly length of stay, more closely resembles that of nonsurgical rather than surgical patients in the renal MDC. Measures of resource use for extracorporeal shock wave lithotripsy are currently limited because of the fact that the procedure was, until March 1985, considered experimental and, therefore, was not covered by Medicare. Consequently, the FY 1984 PATBILL file used for recalibration contains no extracorporeal shock wave cases.

However, we have reviewed limited charge data available from lithotripsy centers engaged in clinical trials, even though these data are from a different period from the remainder of bills used for recalibration, reflect low utilization, and, because clinical trials were underway, include the delivery of services that were furnished as an integral component of the research protocol (services that are not likely to be furnished to patients on a routine basis). In light of this analysis, we believe that the procedure does fit appropriately in the DRGs into which we have placed it. We will continue to monitor the resource intensity of this procedure to assure ourselves that this classification is appropriate and that payment is adequate.

### III. Development of a New Hospital Wage Index

Section 1886(d)(2)(C)(ii) of the Act requires that we standardize the average cost per case of each hospital used to develop the separate urban and rural standardized amounts for differences in area wage levels. Section 1886(d)(2)(H) of the Act requires that the standardized urban and rural amounts for the nine census regions and the national rates be adjusted for hospital area wage levels as part of the methodology for determining the prospective payments to hospitals. To fulfill both requirements, we constructed a wage index to eliminate variations in the average cost per case.

We used calendar year 1981 hospital wage and employment data obtained from the Bureau of Labor Statistics (BLS's) ES 202 Employment, Wages and Contributions file for hospital workers to construct the wage index applied under both of the above provisions of the Act for computing prospective payments to hospitals during FY 1984 and FY 1985. The BLS ES 202 system compiles information on employment and total wages for workers covered by unemployment insurance.

We have been aware since the beginning of the prospective payment system of certain limitations of the BLS data, especially with regard to the lack of information on hours of employment or full-time equivalents. The BLS data provide information only on the number of workers employed at a hospital and their aggregate salaries. As a result, area wage indexes produced from these data do not distinguish between part-time and full-time employees. Although we recognized these shortcomings, we believed the disadvantages were outweighed by the advantage of being able to utilize the best national data available.

In an effort to overcome the limitation of the BLS data with regard to full time and part-time employment, we conducted a survey that we hoped would permit the analysis of options for the construction of an improved wage index. The survey provided for the extraction of specific hospital salary and fringe benefit data from the Medicare cost report for hospital fiscal years ending in calendar year 1982, and for the extraction from hospital records of data on paid hours worked. A complete description of the survey, as well as the survey results, can be found in the proposed rule published on July 3, 1984 (49 FR 27439), the final rule published on August 31, 1984 (49 FR 34764), and the June 10, 1985 proposed rule (50 FR 24375).

As we stated in the proposed rule, we computed two hospital wage indexes using the data from the 5,595 hospitals that were included in our survey data base. Both of these indexes were presented in our March 29, 1985 report to Congress on the HCFA wage index. One index is derived from gross hospital salaries; the second index is developed from adjusted gross hospital salaries. Adjusted gross salaries are defined as the net of wages for and hours worked by interns and residents, personnel employed in nonhospital cost centers, and hospital-based physicians.

The two indexes were developed from different categories of hospital workers. The index based on gross salaries and wages measures the difference from area to area in gross hospital wages; that is, the wages paid to all hospital employees, including interns and residents, provider-based physicians, and workers employed by the hospital but working in areas of the facility other than the hospital inpatient area. The other index is based on adjusted salaries and hours; that is, it eliminates the effect of interns and residents, provider-based physicians, and hospital workers in areas of the facility other than the hospital inpatient area.

Both indexes control for regional differences in part-time employment since each is based on the average hourly wage in each urban or rural area. However, because many hospitals have indicated that they had difficulty in determining the wages and salaries and hours worked for the excluded worker categories used to develop the adjusted gross wage index, that index is probably not as accurate as the gross wage index.

Therefore, we proposed to use the gross wage index, since we believe it is the better of the two wage indexes derived from the HCFA wage survey.

In the proposed rule (50 FR 24377), we set forth the method we used to compute the gross wage index as it appeared in that document. However, as is explained in detail in the comments and responses that appear below, we have incorporated corrected data into the survey data base. Therefore, the following is a corrected explanation of the method used to compute the gross wage index:

The method used to compute the gross wage index is as follows:

*Step 1*—Each of the 5,602 (5,595 in the NPRM) non-Federal acute care hospitals subject to the prospective payment system, for which a properly completed survey form has been received, is classified into its appropriate urban or rural area based on the Executive Office of Management and Budget's (EOMB's) metropolitan statistical area (MSA) definitions including the changes that were announced on June 27, 1985 and were effective June 30, 1985, (the NPRM used those definitions in effect as of June 10, 1985) and which would be recognized for prospective payment purposes beginning October 1, 1985.

*Step 2*—For each hospital, the total gross hospital salaries (item 4 on the survey report) are inflated from the end of the hospital's cost reporting year through the end of calendar 1982 using the annual 1982 rate of increase in the wages and salaries portion of the hospital market basket. The annual rate used was 11.0 percent. This is done to eliminate any distortion in the data caused by differing hospital cost reporting years.

*Step 3*—For each hospital, the inflated gross hospital salaries computed in step 2 are divided by the reported number of total paid hours worked (item 12 on the survey report) to yield an average hourly wage.

*Step 4*—Hospitals with an aberrant average hourly wage, which is defined as an average hourly wage either less than $3.35 (the minimum wage in 1982) or greater than $19.58 (2.5 times the 1982 national average hourly hospital wage as reported in BLS' *Employment and Earnings Bulletin* as of February 1984), are excluded. This results in the elimination of records from 63 (73 in the NPRM) hospitals.

*Step 5*—Within each urban or rural area, the result computed in step 2 is summed for all remaining hospitals to yield the total gross hospital salaries in each area.

*Step 6*—The total gross hospital salary result computed in step 5 is divided by the corresponding total number of paid hours worked to yield an average hourly wage for each urban or rural area.

*Step 7*—The arithmetic mean of the result in step 6 is computed across all urban and rural areas to obtain the national average hourly hospital wage based on gross salaries. The national average is $8.0253 ($8.03 in the NPRM).

*Step 8*—For each urban or rural area, the hospital wage index is calculated by dividing the average hourly wage computed in step 6 by $8.0253 ($8.03 in the NPRM), the national average.

On July 18, 1984, while we were conducting our survey, Congress enacted section 2316 of Pub. L. 98–369, which requires the Secretary to conduct a study to develop an appropriate wage index that specifically addresses the part-time employment problem. As mentioned above, this study was presented to Congress on March 29, 1985. In addition, section 2316(b) specifies that any changes made in the wage index under that provision of the law are to be retroactive to cost reporting periods beginning on or after October 1, 1983. We proposed to make the appropriate payment adjustments to overpaid and underpaid hospitals throughout FY 1986. The survey-based wage index used to determine the amount of a hospital's underpayment or overpayment would be based on the recognized urban/rural definitions in effect for the entire Federal fiscal year for which the payment adjustment determination is being made. We believe that spreading the payment adjustments over the course of one year, rather than requiring lump-sum payments, would minimize the negative impact on overpaid hospitals. Therefore, to accomplish these adjustments, we proposed that overpaid hospitals make 26 equal payments to us throughout FY 1986. Conversely, we would make 26 equal payments to underpaid hospitals over the same period of time.

We received 80 pieces of correspondence that contained comments on the proposed wage index. Reactions to our changes ranged from very positive to very negative; however, the majority of the commenters were in favor of the survey-based gross wage index. We have considered all of these comments quite carefully and have decided to proceed with implementation of the survey-based gross wage index as we proposed in the NPRM. Our reasons for doing so were set forth at length in the NPRM and are further explained in our responses to comments below.

*Comment:* Several commenters questioned the accuracy of the survey-based gross wage index, pointing out significant changes in the values of the index for specific locales that were perceived by the commenters as not being credible changes. Some commenters were highly critical of the way in which the survey was coordinated, characterizing the instuctions as ambiguous and citing the questionable nature of the preliminary survey results that led to the need for a follow-up effort to validate the accuracy of the initially reported records. We received several comments requesting that implementation of the gross wage index be delayed until we fully disclose all information that has a bearing on the validity and reliability of the survey and an opportunity for further public comment. Other commenters requested that hospitals be afforded an opportunity to submit corrected records if they can demonstrate that survey errors resulted in incorrect gross wage index values for their particular area.

*Response:* We wish to point out that the survey form and instructions for collecting hospital financial data in order to address the part-time employment limitation of BLS ES 202 records were reviewed and approved by a workgroup that included representatives from HCFA, the American Hospital Association, and State hospital associations from Connecticut, Ohio, Louisiana, Nebraska, and California. The survey instrument was designed with a view toward balancing the need to obtain comprehensive data by occupational category in order to correct all of the technical limitations of the BLS ES 202 data base with the desire to obtain data quickly in order to resolve the part-time employment problem in time for the FY 1985 update of the prospective payment rates.

For reasons that were discussed in detail in the July 3, 1984 proposed rule (49 FR 27439) and the August 31, 1984 final rule (49 FR 34764), the disappointing quality of the initial survey results precluded our adoption of a revised wage index effective October 1, 1984. Therefore, we subsequently afforded each hospital the opportunity to check the accuracy of the survey data reported for that facility. On July 2, 1984, we informed the Medicare fiscal intermediaries of this decision and directed them to send a letter to each hospital requesting that they check and, if necessary, correct the data reported. In our notification, we pointed out the sources of some of the more common errors in the survey reports, and hospitals were asked to review and ensure the accuracy of key data items.

In order to promote wide participation in the survey and ensure hospital cooperation in our validation effort, the various national and State hospital associations encouraged their respective memberships to complete the survey reports and return them to us promptly. Hospitals were furnished the name and telephone number of a contact in HCFA central office who could answer any questions concerning the proper completion of the survey report. In addition, HCFA staff attempted to resolve any discrepancies on validated survey reports by telephoning the hospital directly. In many instances, repeated contacts were made. Therefore, we must conclude that all hospitals wishing to participate in the wage index survey have been given sufficient opportunity to submit accurate wage and employment data.

With respect to the significant changes in the gross wage index compared to the 1981 BLS measures for certain locales, the HHS Office of the Inspector General (OIG) and our fiscal intermediaries audited key data items from the survey reports of 173 hospitals. Many of these hospitals were located in areas in which the Federal portion of the prospective payment rate, as computed by using the gross wage index, differed from that calculated by using the 1981 BLS index by more than 10 percent. Any corrections were incorporated in the survey data base. OIG concluded that, notwithstanding any differences between the reported and audited survey data for specific hospitals, their analysis indicated a very high degree of accuracy between the audited and reported data overall. Subsequent to the OIG's audit, additional corrected reports were added to the summary data base used to calculate the final gross wage index values that appear in Tables 4a and 4b of the addendum to this final rule. Some of these revised data were audtied, as indicated in the responses to comments below.

With respect to the comment that we should furnish an additional opportunity for public comment prior to implementing the revised wage index, we do not see how this would serve a useful purpose. Our report to Congress on the hospital wage index required by section 2316(a) of Pub. L. 98–369, OIG's report of its audit findings, as well as the data used to compute gross and adjusted gross wage indexes, have been available to the public both before and since the publication of the June 10, 1985 proposed rule.

We have expended considerable effort to provide hospitals with repeated opportunities to participate in the wage index survey and to submit corrected wage and employment records used to develop the gross wage index. Both HCFA and OIG have audited hospital records in areas in which implementation of the gross wage index

would significantly alter the Federal portion of the prospective payment rates to ensure the accuracy of the reported data. We have extended the deadlines for hospitals to submit their survey reports several times in order to obtain high quality records from as many hospitals as possible, which resulted in our delaying the issuance of the wage index report to Congress. Because we believe that hospitals have been provided ample opportunity to participate in the survey and to submit accurate records for purposes of constructing the gross wage index, we plan no further changes to the wage index values published in the addendum to this final rule.

*Comment:* Several commenters indicated concern about errors in the survey data that have been detected since the data collection was terminated (in order to allow HCFA to prepare the wage index report that was sent to Congress on March 29, 1985).

*Response:* We carefully reviewed any additional data received, as well as accompanying narrative, to determine the validity of altering the certified survey from data. The corrections received fell into four categories: corrections to the adjusted index data; minor changes to the gross wage index data; significant changes to the gross wage index data; and incorrect or inappropriate changes to survey data.

Many of the corrections to the survey data would have had an impact on only the adjusted wage index. Since we are not adopting the adjusted wage index, it is unnecessary to act on these corrections.

Each suggested change to the gross wage index data was reviewed for correctness and its impact on the area's wage index. If the reguested change had a significant impact in terms of average hourly wage amounts compared to the average hourly wage in the area or if the data submitted had not been certified by the hospital, we asked for further verification in the form of an audit. These audits were conducted by the Medicare fiscal intermediaries. Information contained in the audits was evaluated, and in most cases, the audited data have been incorporated in the final wage index values.

Information submitted suggesting that changes be made in recognition of events subsequent to the data collection year were not accepted as valid. These changes were not accepted because the survey was designed to extract uniform data covering the latest full cost reporting period in which audited data were expected to be available. Therefore, changes suggested as a result of subsequent events were not accepted. Subsequent events will be recognized in any later wage and employment data used to update the wage index.

In summary, we received additional data from 140 hospitals. Of these 140, we did not accept data from 40 for a number of reasons (for example, data from the wrong year). The data from 63 hospitals made no difference to the gross wage index because they either reflected no change to the data already on file or contained corrections to the data used in computing the adjusted wage index. Of the remaining 37, we accepted the changes from 13 hospitals without further review because the changes in the data had only a minimal effect on the hourly wage in the area, and we audited 24 hospitals. As a result of the audits, we accepted changes from 19 hospitals and did not accept changes from the remaining five. At this time, we anticipate that no further corrections will be made.

A number of hospitals also submitted revised data that they believe should have been included in the survey. A particular area of concern involved the use of contract labor by hospitals. While some hospitals may have included contract labor costs as salary costs on their Medicare cost reports, these costs are not generally considered salary costs. Therefore, in most cases, the wage data collected from the 1982 cost reports did not include contract labor. When the wage survey was initially designed, the workgroup members agreed that, in many cases, fees paid for contract labor may not be representative of area wages. Therefore, it was decided that no special attempt would be made to collect these data. (In fact, the survey form approved by the workgroup provided for the reporting of data that would allow for the removal of any contract labor costs that hospitals had happened to include in salary costs). The workgroup was also concerned that the survey impose as little additional reporting burden on hospitals as possible.

In light of the history of the development of the wage survey, we did not revise the data of any hospital that asked that its report be revised to include the costs of contract labor not reported as salaries on the Medicare cost report. While the question of whether a wage index should reflect these costs is a valid policy issue, it is an issue that is properly addressed on its own, and not in the context of corrections for the current survey wage data. Moreover, revising the data as these commenters indicated would have had the effect of raising the gross wage index for affected areas. This would have unfairly advantaged them compared to hospitals in other areas that would not have received the benefit of having their data similarly revised.

*Comment:* One commenter maintained that the proposed gross wage index did not differ materially from the BLS 1981 index currently in use, citing the reported .85 Pearson product-moment correlation between the two measures of hospital wage levels. The commenter suggested that our proposed adoption of the gross wage index on the basis of its similarity to an index that has been widely discredited is dubious at best.

*Response:* We have not cited the high correlation between the 1981 BLS and the survey-based gross wage indexes as evidence that supports that adoption of the latter measure. In our wage index report to Congress, we stated that this degree of correlation supports the position that despite the technical limitations of the BLS data, the use of aggregated data from all hospitals in each urban and rural area subject to indexing tends to mitigate the effect of any potential distortion for which no specific control was made. The correlation coefficient obtained, while statistically significant, only explains 72 percent of the variation in the BLS wage index associated with that of the gross index. While the BLS 1981 and gross wage index values are similar for many areas, there are also significant differences between the two values for other locales. We agree, however, with the commenter's implication that a very high degree of congruence between the BLS and either of the two survey based wage indexes (for example, as reflected in a perfect correlation coefficient of 1.0) would have been strong evidence in support of *not* revising the current index. Such a result would have indicated that the two survey-based wage indexes are equally as good at predicting differences in hospital wage levels as is the BLS wage index, and that replacing the BLS index with one of the others would not have yielded a superior wage index.

*Comment:* Several commenters pointed out that the gross wage index, while an improvement over the BLS measure, still fails to recognize the generally higher labor costs associated with hospitals within the more economically interdependent central counties of each urban area. These commenters recommended that we apply separate wage indexes to urban areas subdivided into "core" and "ring" (that is, inner city and suburban) counties.

*Response:* We have previously acknowledged that the current urban definitions that form the basis for constructing the area wage index may

not recognize the widely varying hospital labor conditions that can prevail within each locale. The implication of this comment, which is similar to ProPAC's recommendation 13 (see section V.B. of this preamble for a discussion of this recommendation), is that an alternative means for aggregating counties to obtain wage indexes more reflective of economically integrated areas needs to be investigated, not only for urban but for rural areas as well. Because of their greater specificity, the use of "core" and "ring" urban distinctions would, in principle, permit more precise urban wage index values. In practice, however, it is impossible to designate boundaries that will be completely satisfactory to all hospitals. Before any revised urban or rural definitions are adopted for the purpose of modifying the area wage index, we believe extensive research and analysis of potential impact will be necessary. Although we are examining other classification systems such as the Department of Commerce's Bureau of Economic Analysis economic areas, we intend to proceed carefully and must be certain that any alternative labor market definitions are an improvement over the current MSA/non-MSA classifications.

*Comment:* In the proposed rule (50 FR 24377), we explained that the denominator of each locale's gross wage index is the mean of the average hourly gross hospital wage computed for all urban and rural areas. The average hourly wage for each urban or rural area is weighted equally in determining the national average. One commenter maintained that using this method for computing the national average hourly hospital wage was upwardly biased and served to depress the wage index for areas in which hospital wage levels are lower. It was recommended that a more appropriate method would be to use a weighted national average in which each area's average hourly wage was weighted by the total number of paid hours worked in each locale.

*Response:* We believe that the current method of computing the national average hospital wage used as the base to develop the area wage index is logical and allows an understanding of interarea differences in wage levels. Each locale is weighted the same, regardless of the number of hospitals or size of the hospital labor force in the area. However, the choice of the base (that is, the national average wage level) used to index each area's average hourly hospital wage would have no effect on the Federal portion of a hospital's prospective payment, as long as the same wage index is used consistently to develop the labor-deflated regional and national rates and multiplied by the appropriate regional/national rate to derive the blended payment rates for the urban and rural locales. The following greatly simplified example (in which we assume that there are only two census divisions rather than the actual nine) demonstrates our point:

Urban areas A, B, C, D, and E each contain one hospital. Areas A and B are located in Census Division 1 while the remaining areas are in Census Division 2. Each hospital's labor cost per discharge, average hourly wage, area wage index, wage index deflated labor cost per discharge, and labor-related Federal portion of the prospective payment rate reflecting the FY 1986 regional/national blend are as follows:

| Region | Area | Labor cost per discharge | Average hourly hospital wage | Wage index (WI) | Deflated labor cost per discharge |
|---|---|---|---|---|---|
| 1 | A | $4,000 | $10.00 | 1.2500 | $3,200 |
| 1 | B | 3,000 | 8.00 | 1.0000 | 3,000 |
| 2 | C | 2,625 | 7.00 | .8750 | 3,000 |
| 2 | D | 2,250 | 9.00 | 1.1250 | 2,000 |
| 2 | E | 3,000 | 6.00 | .7500 | 4,000 |

National Average Hourly Hospital Wage $8.00.
Region 1 Labor Deflated Standardized Amount $3,100.00.
Region 2 Labor Deflated Standardized Amount $3,000.00.
"National" Labor Deflated Standardized Amount $3,040.00.

CALCULATION OF LABOR-RELATED FEDERAL RATES

| Region | Area | |
|---|---|---|
| 1 | A | .50 ($3,100.00×1.2500)+<br>.50 ($3,040.00×1.2500)=$3,837.50 |
| 1 | B | .50 ($3,100.00×1.0000)+<br>.50 ($3,040.00×1.0000)=$3,070.00 |
| 2 | C | .50 ($3,000.00×.8750)+<br>.50 ($3,040.00×.8750)=$2,642.50 |
| 2 | D | .50 ($3,000.00×1.1250)+<br>.50 ($3,040.00×1.1250)=$3,397.50 |
| 2 | E | .50 ($3,000.00×.7500)+<br>.50 ($3,040.00×.7500)=$2,265.00 |

In the example below, we perform the same calculations with the exception of computing the area wage index using an arbitrary national average hourly wage of $7.00. (This average need not be set arbitrarily. It could represent a case-weighted national average or average derived by weighting each area average using the total number of paid hours worked in each locale.)

| Region | Area | Labor cost per discharge | Average hourly hospital wage | Wage index (WI) | WI deflated labor cost per discharge |
|---|---|---|---|---|---|
| 1 | A | $4,000 | $10.00 | 1.4286 | $2,799.94 |
| 1 | B | 3,000 | 8.00 | 1.1429 | 2,624.90 |
| 2 | C | 2,625 | 7.00 | 1.0000 | 2,625.00 |
| 2 | D | 2,250 | 9.00 | 1.2857 | 1,750.02 |
| 2 | E | 3,000 | 6.00 | .8571 | 3,500.18 |

Arbitrary National Average $7.00.
Region 1 Labor Deflated Standardized Amount $2,712.42.
Region 2 Labor Deflated Standardized Amount $2,625.07.
"National" Labor Deflated Standardized Amount $2,600.01.

CALCULATION OF LABOR-RELATED FEDERAL RATES

| Region | Area | |
|---|---|---|
| 1 | A | .50 ($2,712.42×1.4286)+<br>.50 ($2,660.01×1.4286)=$3,837.53 |
| 1 | B | .50 ($2,712.42×1.1429)+<br>.50 ($2,660.01×1.1429)=$3,070.07 |
| 2 | C | .50 ($2,625.07×1.0000)+<br>.50 ($2,660.01×1.0000)=$2,642.54 |
| 2 | D | .50 ($2,625.07×1.2857)+<br>.50 ($2,660.01×1.2857)=$3,397.52 |
| 2 | E | .50 ($2,625.07×.8571)+<br>.50 ($2,660.01×.8571)=$2,264.92 |

Except for slight differences due to rounding, the labor-related Federal amount in each area is the same regardless of whether the national average hospital wage used to develop the area wage index is area-weighted, hospital-weighted, or otherwise selected.

The following formula expresses the calculation of the labor-related portion of the standard payment amounts (regional or national):

$$Yj = \frac{1}{n} \sum_{i=1}^{n} \frac{Xi}{Wi/Z}$$

where Yj is the labor-related portion of the $j^{th}$ standard payment amount, Xi is the labor cost per discharge of the $i^{th}$ hospital, Wi is the average hourly wage in the area in which the $i^{th}$ hospital is located, Z is the national average hourly wage weighted in any manner one chooses, and n is the number of the hospitals in the area of the $j^{th}$ standard payment amount.

Since Z does not vary across hospitals in the summation, the equation above can be written:

$$Yj = \frac{1}{n} \left(Z\right)\left(\sum_{i=1}^{n} \frac{Xi}{Wi}\right)$$

The labor-related regional or national Federal payment (Pij) for the $i^{th}$ hospital in the area of the $j^{th}$ standardized payment amount is expressed as the product of the labor-related portion of $j^{th}$ standardized payment amount and the wage index value applicable to the $i^{th}$ hospital:

$$Pij = Yj\left(\frac{Wi}{Z}\right)$$

$$\text{or } Pij = \frac{1}{n}\left(Z\right)\left[\sum_{i=1}^{n} \frac{Xi}{Wi}\right]\frac{Wi}{Z} = \frac{1}{n}\left(\sum_{i=1}^{n} \frac{Xi}{Wi}\right) Wi$$

Since Z, the national average hourly wage, appears in the numerator and the denominator of this expression, it cancels out. Therefore, the method of weighting the average national wage has absolutely no effect on the labor-related Federal payment as long as the wage index is consistently applied in both standardization and payment.

*Comment:* Our commenter stated that the adoption of the gross wage index requires that the labor-related component of the cost per discharge values used to develop the regional and national standardized amounts be restandardized. It was alleged that the need to restandardize resulted from the method used to calculate the national average hourly hospital wage used as the base to compute each locale's index in which each urban and rural area is weighted equally. The commenter maintained that the need to restandardize could be avoided by reweighting the national average used as the denominator of the wage index to reflect the proportion of cases in each urban and rural area.

*Response:* We do not understand how reweighting the national average hospital wage would obviate the need for restandardizing the labor-related national and regional standardized amounts. As we discussed in the preceding comment and response, the choice of the national average hospital wage used as the base to calculate the wage index values is irrelevant as long as the resulting indexes are used consistently in developing the labor-deflated regional and national standardized amounts and multiplying these amounts by the area's applicable wage index. We restandardized the cost per discharge values used to derive the labor-deflated regional and national standardized amounts only because of the adoption of a new type of wage index.

We believe that revising the methodology for constructing the wage index does not avoid the need for restandardization but rather requires it, particularly since the survey-based gross wage index was explicitly designed to capture a different measure of area wage levels and, as a consequence, reflects different relative wage levels among areas. It is the effects of this difference that restandardization is intended to remove from the adjusted costs per case used to develop the standardized amounts.

Had we used a wage index developed from BLS ES 202 records for calendar year 1982 or 1983, we would in fact not have restandardized the labor-related national and regional standardized amounts. The reason is that the standardized payment amounts already have the effects of wage differences across areas removed from them, as such wage differences are measured by BLS. Any changes in BLS index values in subsequent years reflect different wage levels relative to an earlier time, not the effects of a different means of constructing an index. Those changes are precisely the kinds one would want the payment system to recognize. Restandardizing each year without new data potentially distorts the resultant payment rates, since it is based on the premise that variations across hospitals in a single year can be attributed repeatedly to subsequent years' events and relationships.

The point of standardizing for wages is to assure that each hospital's costs have been adjusted to what they would theoretically be if each hospital faced the same wage level as the national average. If this is successfully accomplished by whatever measure is

chosen for each hospital's wage levels relative to the national average, then it is never necessary to restandardize again as long as the type of index is not changed.

*Comment:* Several commenters endorsed the use of the adjusted gross wage index rather than the gross measure, pointing out that the adjusted gross index excludes salaries attributable to interns and residents, hospital-based physicians, contract labor, and employees working in nonhospital areas such as provider affiliated home health agencies and skilled nursing facilities. Because the adjusted gross wage index was constructed to control partially for differences in employment mix among hospitals by excluding salaries for physicians and employees engaged in hospital-based activities secondary to the provision of hospital services, these commenters believe that the adjusted gross index resulted in more comparable indexes among areas by reducing distortion due to area differences in occupational mix.

*Response:* Of the two survey-based wage indexes, we believe that the adjusted gross wage index is theoretically the better measure of hospital wage levels because of the greater uniformity of hospital occupational categories used in its construction. However, during the survey, many hospitals indicated they had difficulty in accurately determining the salaries and hours worked for the hospital worker categories excluded in developing the adjusted gross index. This is understandable since hospitals are not ordinarily required to record where employees are working at a level of detail that easily permits their classsification into separate categories. Therefore, the adjusted gross wage index is probably not as accurate as the gross wage index, a point that was clearly made in the wage index report to the Congress. Because the precision of the adjusted gross wage index is more problematic, we have addressed the part-time employment limitation of the current BLS index by implementing the gross wage index.

*Comment:* Several hospitals maintained that our use of the gross wage index rather than the adjusted gross wage index to develop the FY 1986 prospective payment rates unfairly penalizes those facilities whose gross wages did not include salaries for the worker categories excluded in deriving the adjusted gross measure. Compared to hospitals in the locales for which the gross wage index was constructed from survey data that includes salaries for the excluded categories, such as hospital-based physicians and contract labor, these hospitals pointed out that it is likely that their applicable gross wage index was understated. These commenters requested that either the adjusted gross wage index be used to develop the FY 1986 update of the prospective payment rates, or that hospitals be permitted to have their gross wage indexes recalculated to include the employee categories for which wages and salaries were not previously reported as gross salaries on the 1982 cost reports used for the wage index survey.

*Response:* We have not adopted the adjusted gross wage index for reasons explained in our response to the proceding comment. Compensation to hospital-based physicians and contract labor expenses are not supposed to be reported as salaries on the Medicare hospital cost report and ususally are not so reported. These expense categories, while they may include salaries for the affected physicians on the hospital's staff and wages for contracted workers, often include other remuneration and contract employer overhead expenses that should not be considered hospital wages. Therefore, these expenses are usually classified as "other" expenses on Worksheet A of the Medicare cost report and would not have been considered part of gross hospital salaries in completing the wage index survey report form.

If all hospitals had properly completed their 1982 cost reports that were used in the survey, both the gross and adjusted gross wage indexes would have excluded salaries for hospital-based physicians and contract labor. The survey instructions and July 2, 1985 letter requesting hospitals to verify the accuracy of the initially reported survey data (see Appendixes C and D of the March 29, 1984 wage index report to Congress) explicitly provided for the exclusion of salaries attributable to interns and residents, hospital-based physicians, contract labor, and employees working in nonhospital cost centers in reporting adjusted salaries and paid hours *only to the extent* that these figures were included as total gross salaries on Worksheet A of the hospital's cost report. We are not implementing the adjusted gross wage index. Therefore, hospitals that did not include contract labor expenses and salaries for provider-based physicians in reporting their gross salaries and total paid hours on their survey reports because their 1982 cost reports were completed correctly should not be permitted to have their gross wage indexes recalculated to include these figures.

*Comment:* In our proposed rule, we specifically solicited comments on how a survey-based wage index should be updated if we adopted such an index to develop the FY 1986 prospective payment rates. We received only a few comments in response to our solicitation. One commenter believes that if a survey-based wage index is implemented, we should establish a system for regularly updating the data used to complete the index. However, the preferred means for accomplishing this was not specified. Another commenter recommended use of the Medicare cost report as the appropriate instrument for obtaining the necessary wage and employment data to develop a more refined index. One industry association endorsed the use of a survey approach to obtain the required data, pointing out that the information necessary to compute the wage indexes should be more current than that contained in the cost reports.

*Response:* We believe that a method needs to be established in order to update the gross wage index, and we are committed to maintaining the quality and timeliness of this data. We are undecided as to how these goals could best be accomplished. In 1981, we proposed revising the cost report to obtain standardized wage and employment information to develop an improved wage index. However, at that time, certain segments of the industry opposed the use of the cost report for this purpose because of concerns over the disclosure of hospital-specific salary records and the additional reporting burden.

We believe that we can address these concerns while at the same time safeguarding the public's access to Medicare program data. Because the data elements that would need to be collected for obtaining more current and refined hospital wage and employment information will have a considerable bearing on selection of the appropriate reporting vehicle, we are deferring a final decision on how to update the gross hospital wage index. We believe further consultation with the industry is appropriate before proceeding any further on this issue.

*Comment:* One commenter suggested that the hospital industry be given access to the wage survey information in advance of its implementation so that it can validate its accuracy.

*Response:* We have worked with the hospital industry since the wage index survey began. The survey form itself was developed by a workgroup that was

comprised, in part, of several members of the hospital industry. In addition, each hospital was afforded the opportunity to validate the correctness and accuracy of the survey data. Over 92 percent of all hospitals subject to the prospective payment system submitted signed forms validating the completeness and accuracy of the data submitted. In addition, the data for a number of hospitals have been audited, and changes or corrections were made if appropriate.

In this connection, it should be noted that the Department's OIG, in a report submitted to the Undersecretary, stated that ". . . our analysis of these statistical data indicated a very high correlation of accuracy between the wage data reported to HCFA and the results of the audits. In fact, the correlation coefficient between the reported wages and hours and the wages and hours verified during the audits was .9999. This correlation coefficient is a statistical measurement of the strength of the relationship between the reported data and the verified data. Mathematically, the correlation coefficient cannot exceed +1 nor be less than −1. The closer a computed correlation coefficient is to one of these values, the stronger the relationship. A correlation coefficient of .9999 shows that providers generally reported accurate wage and hour data to HCFA."

*Comment:* Several commenters noted that while the gross wage index represented an improvement over the current BLS wage index because of its resolution of the part-time employment problem, the revised wage index still did not address the remaining technical limitations of BLS ES 202 records that prevent the construction of a more precise measure of area wage levels. These include the failure of the gross wage index to account for area variations in hospital fringe benefits, occupational/skill mix, and differences in labor markets not accounted for by the MSA/non-MSA definitions. Several of these commenters recommended that we undertake additional studies to further improve the gross wage index to account for these factors. Other commenters proposed that we make no change from the present BLS wage index until data can be obtained that would permit further analysis of these problems.

*Response:* We do not believe that the inability of the gross wage index to account for all of the factors that may be desirable in developing a very precise measure of area wage levels should present an obstacle to adopting an index that controls for local variation in the employment of part-time hospital personnel. Both the industry and Congress have advocated the adoption of a revised wage index that corrects the part-time employment deficiency of the index developed from BLS ES 202 hospital wage and employment data as soon as possible. Because this problem can now be addressed, we do not believe that delaying its resolution by deferring the implementation of a revised wage index would be appropriate.

Although the wage index survey solicited hospital employee health and welfare expenses (that is, fringe benefit costs), we did not compute wage indexes using the reported figures. The wide variability in the amount and scope of employee health and welfare expenses, coupled with the generally poor quality of the data reported, would have introduced a source of error in the development of a new hospital wage index that could have negated any increased precision due to correction of the part-time employment problem. However, further research is warranted on this issue to determine the degree to which hospitals in high and low wage areas weight their compensation between direct remuneration and additional fringe benefits. A potential future modification of the wage index to include a standard mix of fringe benefits has not been ruled out. For reasons explained in response to a previous comment, we did not adopt the adjusted gross wage index, which attempted to partially control for area differences in hospital occupational mix. Neither did we attempt to adjust the urban and rural definitions to better accommodate actual hospital labor markets. We believe further research and industry consultation are required before any legislative or regulatory proposals on these issues are recommended.

*Comment:* Although many commenters endorsed the use of the gross wage index because of its correction of the part-time employment limitation of the current BLS measure, several expressed strong concerns over its implementation retroactive to October 1, 1983. In several instances, affected hospitals estimated the adverse financial impact that retroactive implementation of the gross wage index would pose for facilities that would incur overpayments. Hospitals that perceived themselves to be particularly disadvantaged generally recommended the adoption of the gross wage index on a prospective basis only. Conversely, facilities that would receive additional payments if the gross wage index were adjusted retroactively generally favored its implementation effective October 1, 1983, and cited our obligation to comply with section 2316(b) of Pub. L. 98–369.

*Response:* We wish to point out that we have no administrative discretion not to comply with the provision. Section 2316(b) prescribes that any revised wage index that addresses the part-time employment limitation be implemented retroactively to October 1, 1983. Accordingly, we intend to meet our statutory obligation and make the appropriate payment adjustments to overpaid and underpaid hospitals based on the urban/rural definitions in effect for the Federal fiscal year for which the payment adjustment determinations must be made. Absent any Congressional action on this issue, we will begin making refunds to underpaid hospitals and collecting from overpaid hospitals after April 1, 1986. Detailed instructions to the Medicare fiscal intermediaries for accomplishing these adjustments will be issued as soon as possible.

*Comment:* Two comments were received endorsing the use of the survey-based gross wage index but recommending that its implementation by progressively phased-in over time by blending it with the 1981 BLS wage index so as to mitigate any adverse financial impact. One commenter supported a 50 percent blend between the 1981 BLS index and the gross wage index effective October 1, 1985. The gross wage index proportion would be increased to 75 percent of the blend beginning October 1, 1986 with full phase-in achieved in FY 1988. Other commenters recommended immediate implementation of the gross wage index retroactive to October 1, 1983, but suggested that any recoupment of overpayments be spread over two years rather than one year as originally proposed.

*Response:* We believe that phasing in the new wage index through a gradually increasing blend with the present BLS measure would only serve to perpetuate any existing distortion in the BLS index caused by its inability to account for local variation in hospital part-time employment. Therefore, we have not adopted this recommendation. However, we are concerned with mitigating any negative financial consequences for hospitals for which implementation of the new gross wage index would cause severe hardship. Therefore, as we proceed to develop methods of implementing the retroactivity provision, we will consider alternatives that would help reduce any adverse financial impact on these hospitals.

*Comment:* One commenter not only endorsed the use of the gross wage index retroactive to October 1, 1983, but also recommended its implementation for hospitals that exceeded their section 223 cost limits beginning in 1981. This commenter stated that hospitals that were disadvantaged by a lower wage index than would be justified compared to the gross wage index never received proper reimbursement from 1981 up to the present.

*Response:* Although adoption of the gross wage index requires its implementation retroactive to October 1, 1983 under section 2316(b) of Pub. L. 98–369, we will not go beyond the law by extending the application of the gross wage index to earlier reporting periods. The wage indexes used in connection with the annual updates of the cost limits prior to the establishment of the prospective payment system were based on the latest best available data consistent with a national hospital reimbursement system. We do not propose now to erode the prospective nature of the cost limits by retroactively applying a statutory provision only intended for the prospective payment system.

*Comment:* One commenter, citing the table that appeared in the impact analysis contained in the proposed rule (50 FR 24438), pointed out that the effect of implementing the gross wage index was a reduction in the payment of every bed-size class of rural hospitals. Thus, this commenter claims that the proposed wage index does not satisfy the original intent of either Congress or HCFA that a revised wage index correct the inadequacy of the prospective payment amounts to rural hospitals because of their greater utilization of part-time employees.

*Response:* We disagree with the commenter's premise. The purpose of adopting a revised wage index is not to assist a particular class of hospitals but to correct an acknowledged technical deficiency of the present BLS index; that is, its inability to account for local variation in hospital part-time employment. The fact that certain urban and rural hospitals may incur reductions in their total payment amounts as a result of the adoption of a more refined wage index is not an unexpected outcome of an improvement in the system. Whether particular hospitals as a class are disadvantaged or advantaged should have no bearing on our decision to replace the BLS wage index with an improved measure of area wage levels. However, we note that, while rural hospitals as a class do not benefit, many rural hospitals will receive increased payments.

*Comment:* One commenter pointed out that labor-related costs under the prospective payment system comprise approximately 80 percent of total inpatient operating costs. The commenter believes that hospital labor costs as a proportion of total inpatient costs have decreased over the past two years. The commenter recommends that we recognize this trend by applying the wage index to a smaller proportion of inpatient operating costs per discharge in developing updated prospective payment rates.

*Response:* Revisions in the market basket cost weights, including those that are considered labor-related for purposes of applying the hospital wage index, are presently under review as part of an overall rebasing and updating of the hospital input price index using later data. Once the necessary review and analyses are complete, revised market basket weights may be implemented in connection with further updates of the prospective payment rates. To the extend that the labor-related share of hospital inpatient operating costs is revised, the change will be recognized in the proportion of cost subject to adjustment by the area wage index in developing future prospective payment rates.

*Comment:* We received several comments that advocated that we adjust the nonlabor portion of the standardized amounts to account for geographic variation in nonlabor costs. One commenter maintained that a "labor" adjustment to these costs would not be inappropriate because a significant portion of nonlabor costs contains a labor component.

*Response:* We believe that the application of the hospital wage index to the average proportion of inpatient operating cost representing not only wages but also employee benefits, professional fees, costs of business services, and other miscellaneous expenses partially responds to this concern. In the final notice of the schedule of hospital cost limits for cost reporting periods beginning on or after July 1, 1980 published in the **Federal Register** on June 20, 1980 (45 FR 41868), we stated that the wage index, which is used to reflect area differences in wage levels that occur for a variety of reasons, also acts as a proxy for other variables affecting overall hospital costs that we have been unable to identify.

Now that we have adopted a revised wage index for use in the prospective payment system, the issue of whether we should modify the proportion of inpatient operating costs subject to adjustment by the gross wage index, or consider the development of a specific nonlabor index, will require further investigation and research. Revisions in the market basket cost weights, including those presently considered "nonlabor", are currently under review as part of an overall rebasing and updating of the hospital input price index.

In addition, section 2311(e) of Pub. L. 98–369 requires that we study the advisability and feasibility of varying by DRG the proportion of cost that is considered labor and nonlabor. These investigations will help us to determine whether explicit adjustments to the nonlabor share should be considered further.

## IV. Other Changes to Current Regulations

### *A. Rate of Increase Limits (§ 405.463)*

Section 101 of the Tax Equity and Fiscal Responsibility Act of 1982 (Pub. L. 97–248) added section 1886 to the Act in an attempt to restrain growth of hospital costs. Specifically, as originally enacted, section 1886(b) of the Act set forth a program of control on hospital cost increases. This provision required that we establish a target level for the allowable rate of increase of hospitals' inpatient operating costs per case. In addition, the statute provided for incentive payments for hospitals that keep their costs below the target, and penalties for hospitals that incur costs greater than the target.

This target rate system was expected to apply only to hospital cost reporting periods beginning before October 1, 1985 (section 1886(b)(2) of the Act). However, Pub. L. 98–21, which established the prospective payment system, also extended the target rate system indefinitely for all hospitals excluded from the prospective payment system by repealing section 1886(b)(2) of the Act.

#### 1. Target Rate Percentage

Each hospital's target amount is adjusted annually, before the beginning of its cost reporting period, by an applicable target rate percentage for the 12-month period, prorated based on calendar year target rate percentages. As set forth in section 1886(b)(3)(B) of the Act, as amended by section 601(b) of Pub. L. 98–21, the target rate percentage was the estimated hospital market basket increase factor plus one percentage point.

Section 2310 of Pub. L. 98–369 revised section 1886(b)(3)(B) of the Act to provide that, for cost reporting periods

beginning in FY 1985, the annual target rate percentage to be applied for updating the target rate is equal to the estimated hospital market basket increase factor plus one-quarter of one percentage point. Beginning in FY 1986 (cost reporting periods beginning on or after October 1, 1985), the target rate percentage will be equal to an update factor determined by the Secretary under section 1886(e)(4) of the Act, considering the recommendations of ProPAC under section 1886(e)(2) of the Act.

Currently, § 405.463(c)(3)(i) states that the target rate percentage is equal to the estimated increase in the market basket index plus one percentage point. We proposed to revise § 405.463(c)(3)(i) to reflect the changes made by Pub. L. 98-369. We received no comments on this issue.

2. Exemption for New Hospitals

When we published the regulations implementing section 101 of Pub. L. 97-248 on September 30, 1982 (47 FR 43282), we included a provision that exempted new hospitals from the target rate system (§ 405.463(f)(1)). We exempted new hospitals from the rate-of-increase limits to prevent the distortion inherent in a new hospital's operating cost per case from adversely affecting its target rate reimbursement. This exemption expired at the end of the earliest of—

- The first cost reporting period beginning at least two years after the hospital accepts its first patient; or
- The first cost reporting period beginning on or after October 1, 1985 (that is, the original statutory expiration date for the rate-of-increase limits).

However, when we revised the regulations at § 405.463 in the September 1, 1983 interim final rule, we inadvertently did not delete the October 1, 1985 date from § 405.463(f)(1). Since the reasons for providing a new hospital exemption remain as valid today as when the target rate system was first established, and since the statutory termination date of October 1, 1985 has been repealed, we proposed to revise § 405.463(f)(1) by deleting the October 1, 1985 expiration date for the exemption. We received no comments on this issue.

*B. Exclusion of Alcohol/Drug Hospitals and Units (§§ 412.23 and 412.32)*

In the January 3, 1984 final rule, we developed a set of criteria for the exclusion of hospitals and distinct part units that specialize in alcohol/drug dependency treatment. As provided in §§ 412.23(c) and 412.32, this exclusion terminates on October 1, 1985. However, if the exclusion expires on that date, all excluded alcohol/drug hospitals and units, regardless of their actual cost reporting period, would have to close their books and file cost reports as of September 30, 1985.

Since we originally intended these hospitals and units to be excluded from the prospective payment system for two full years, and because we believe it would be inappropriate to force excluded entities to close their cost reporting periods on September 30, 1985, we proposed to revise §§ 412.23(c) and 412.32. We proposed that the exclusion would expire at the end of the hospital's cost reporting period that began before October 1, 1985.

*Comment:* A large number of comments urged us to continue the exclusion of alcohol and drug treatment units and hospitals. They indicate that the newly reconstructed DRGs for alcohol and drug treatment are an improvement but that further refinements are necessary. The major refinement suggested is an increase in the payment for DRG 437 to reflect a mean length of stay of 16.9 days (instead of the 14.6 days reflected in the proposed rule). In addition, several letters were received from commenters who suggested that the exclusions should remain in place until further research has been done. Some of the letters cited statements in ProPAC's report to the effect that current research is proceeding and suggested that the results of that research be awaited.

*Response:* We note that the initial decision to create a temporary exclusion for alcohol and drug abuse treatment units and facilities was based on allegations by the treatment community and professional organizations that the grouping principles for the DRGs in question were inappropriate and that the resulting payments were generally inappropriate for the types of services clients typically were provided. During the past year, we have worked with our claims data and with NIAAA to develop groupings of cases that are consistent with the pattern in which the services are delivered. We have also made significant improvements in the coding of alcohol and drug cases. As a result, we have developed new DRGs that do follow the pattern in which services are generally provided.

We believe that these DRGs (see section II.B. of this preamble for a discussion of changes made in response to comments) are an appropriate expression of the clinical groupings of individuals who suffer from alcohol and drug abuse and who are in the Medicare age group. Because we have used the FY 1984 Medicare PATBILL file on alcohol and drug treatment cases in acute care general hospitals and excluded alcohol and drug treatment units and facilities to establish the weights, we know that they generally reflect the actual range of resources used during FY 1984 by Medicare hospitals for discharges falling into each new group.

We note that the HCFA research ProPAC refers to was conducted by us and described in the proposed rule (50 FR 24370). The research was concluded and resulted in the DRGs and weights contained in both the proposed rule and this final rule. Some commenters have suggested that the weights should be revised to reflect what they believe to be optimal clinical practice for the types of care they describe in their comments. We have noted in section II.B.1. of this preamble that the weights of the DRGs reflect actual clinical practice in hospitals that participate in Medicare.

We recognize, however, that further improvements in these DRGs are desirable to assure that the weights assigned to them capture the true range of resources used by currently excluded units and hospitals. Our analysis of alcohol and drug abuse claims leads us to conclude that coding practices for these cases need improvement. Although we issued an instruction to institute some improvements in coding, we believe further improvements are desirable and are undertaking them. Also, as noted in section II.B.1. of this preamble, in our discussion of the new alcohol and drug treatment DRGs, we have made some further refinements in the classification system. In order to assure that these DRGs are properly constituted and weighted, we have decided to continue the exclusion for another year for units and hospitals that are currently excluded and continue to be eligible for exclusion. During the next year, we will continue our efforts to improve coding practices and will continue to look at the new groupings we have developed. We believe that these actions will enable us to discontinue the exclusion, for cost reporting periods beginning on or after October 1, 1986.

In deciding to continue the exclusion, we decided to limit the extension to units and facilities that were excluded for their cost reporting period beginning in FY 1985. As noted above and by many of the commenters, our revised DRGs for these cases are greatly improved over the ones currently in effect. Thus, the appropriateness of payments to facilities and units not currently excluded will be improved when this final rule takes effect. Any hospital or unit that has not previously qualified for the alcohol/drug exclusion will be paid on the basis of the revised

DRGs set forth in this final rule. Since our overall objective is to eliminate reasonable cost reimbursement in short-term acute care hospitals, we do not believe it would be appropriate to temporarily exclude units and hospitals that have been operating under the prospective payment system at a time when the accuracy of our payment mechanism for these cases has measurably improved to a point at which the payment is fully adequate.

*C. Review Activities*

1. Responsibility for Medical Review (Subparts C and F of Part 412)

In the January 3, 1984 final rule, we used the term "medical review entity" to describe the various organizations that would be performing inpatient hospital medical review (49 FR 282). Now that the PROs are fully functioning, they have the responsibility for the medical review of hospital claims. Therefore, in Subparts C and F of 42 CFR Part 412, we proposed to replace all references to medical review entities, Professional Standard Review Organizations (PSROs), and to fiscal intermediaries as appropriate, with a reference only to PROs. We received no specific comments on this issue.

2. Limitations on charges to beneficiaries (§ 412.42)

In the January 3, 1984 final rule, we added § 405.472(b)(1)(iii) (since redesignated at § 412.42(c)) to allow prospective payment hospitals to charge beneficiaries for items and services excluded from coverage on the basis of § 405.310(g) (custodial care) or § 405.310(k) (medically unnecessary services) if certain conditions are met and the services are furnished by the hospital We provided this mechanism because the prospective payment system did not change Medicare's coverage rules and was not intended to prevent a hospital from charging a beneficiary for a noncovered service that he or she might choose to receive. In order to ensure that beneficiaries are protected from liability for noncovered services about which they had not been informed, we included § 412.42(c)(3), which requires that the written notice contain specific information.

Since implementation of the PRO program, we have received inquiries from some hospitals and hospital associations in States that either have a State reimbursement control system approved under section 1886(c) of the Act or participate in a demonstration project authorized under section 402(a) of the Social Security Amendments of 1967 (Pub. L. 90–248) or section 222(a) of the Social Security Amendments of 1972 (Pub. L. 92–603), concerning the hospital's authority to charge beneficiaries for custodial or medically unnecessary care. Before the inception of the PRO program, many of these hospitals were delegated the PSRO review function; that is, they could review and deny services by issuing denial letters to beneficiaries. Under the PRO program, however, they no longer are delegated this authority.

Hospitals paid under a State reimbursement control system or demonstration project believe that they are at a disadvantage as opposed to prospective payment hospitals. They argue that they may be faced with situations in which they have to provide medically unnecessary or custodial care and there is no administrative mechanism that enables the hospitals to notify the beneficiary of noncoverage in a manner that the State will find provides a satisfactory basis for Medicaid payment for an ICF level of care in the hospital.

The hospitals can give notices of noncoverage under the waiver of liability regulation (§ 405.332). However, these notices, unlike the notices under the stricter requirements of § 412.42(c) applicable to prospective payment hospitals, can be given without the concurrence of either the attending physician or the PRO. Thus, the States operating under a State reimbursement control system or demonstration project are not prepared to accept these notices as a basis of Medicaid payment to the hospital for an ICF level of care. The hospital must wait for Medicaid payment until the PRO makes a retrospective determination regarding the level of care furnished.

We agreed that these hospitals are at a disadvantage and, therefore, we proposed to amend the regulations by adding a new § 405.308 to provide that the notice requirements of § 412.42(c) rather than § 405.332 would apply when a short-term acute care hospital (that is, a hospital that would be subject to the prospective payment system if it were not under a State reimbursement control system or demonstration project) receiving payment under a State reimbursement control system or demonstration project gives notice that a beneficiary who has been admitted for covered care no longer requires inpatient hospital services.

In the proposed rule, we stated that we had learned that some prospective payment hospitals have inappropriately implemented the notice process required by § 412.42(c), resulting in a detrimental effect on beneficiaries and inappropriate program payments. As we noted, we believe that these difficulties could be eliminated by increased oversight activity, and, therefore, we issued instructions to the PROs on this subject. The instructions (PRO Manual, Interim Manual Instruction, Transmittal No. 85–3) specify that the PROs are responsible for monitoring the notices used by hospitals and provide further guidance on the appropriate content of the notices.

We plan to continue to monitor this situation carefully to ensure that inappropriate notices are not issued. As we stated in the proposed rule (50 FR 24379), we will consider precluding hospitals from billing patients for any services if the situation does not improve. We do not believe that this step will be necessary, however, because our current authority provides a basis for a number of administrative actions to deal with individual hospitals that give inappropriate notices.

We note that the terms of Medicare provider agreements as expressed in 42 CFR Part 489 prohibit a hospital from billing a patient for services that are covered under Medicare. If a hospital does so (that is, if a hospital gives an inappropriate notice and then charges a beneficiary for care), Medicare may terminate its participation agreement. Thus, individual hospitals can suffer the loss of their provider status.

In addition, PROs have specific authority to make claims denials when a readmission is due to a premature discharge or when an unnecessary transfer is made. They also have the authority to recommend sanctions when inappropriate notices are given or when inappropriate care is given. PROs must also confirm any hospital notice of nonconverage with which the beneficiary or his or her physician disagrees. If a PRO finds that the notice is incorrect, a hospital may not bill the beneficiary.

Also, we proposed to revise §§ 412.42(c)(3)(iv) and 412.42(d)(4) to allow the attending physician as well as the hospital or the beneficiary to appeal a PRO's decision as to the validity of a hospital's finding that a beneficiary's stay is no longer covered care. We proposed to make a technical change in §§ 412.42(d) (3) and (4) to indicate that validation of a hospital's findings regarding coverage are made by the intermediary and the PRO (to the extent that there is a medical component to the decision).

We received several comments from hospitals, hospital systems, professional associations, unions, individual physicians, medical groups, and States

about the provisions on charges to beneficiaries. The major comments and issues raised are as follows:

*Comment:* One commenter expressed the view that allowing hospitals that receive payment under a State reimbursement control system or demonstration project to give notices and then charge beneficiaries for custodial or medically unnecessary care undermines Medicare's most basic protection and violates the law. The commenter believes that hospitals and physicians, not beneficiaries, should pay for decisions to keep patients in the hospital unnecessarily.

*Response:* Hospitals in States with a State reimbursement control system are already permitted to charge beneficiaries for medically unnecessary services, subject to the waiver of liability provisions of section 1879 of the Act. The provisions for payment for hospital services in these States do not prevent a hospital from charging a beneficiary for any noncovered services he or she may choose to receive. The new § 405.308 is designed to substitute for the waiver of liability rules governing charges for medically unnecessary continued hospitalization, the more stringent safeguards provided under the prospective payment regulations governing these charges. The rules for prospective payment hospitals, unlike the waiver of liability rules, require the concurrence of the attending physician or PRO before the hospital can give the notice of noncoverage.

It is desirable that hospitals be able to charge beneficiaries for a medically unnecessary continued hospitalization for two reasons. First, these charges are often required in order to induce the beneficiary to make the arrangements necessary to leave the hospital timely. Second, a continued hospitalization, while not medically necessary, may be desirable from the beneficiary's personal point of view. The regulations should not preclude a beneficiary from purchasing continued hospital care if he or she wants it.

*Comment:* One commenter noted that while the proposed regulations would govern the issuance of continued stay denials, other noncoverage letters (for example, at preadmission) are governed by Medicare's waiver of liability regulations. The commenter urged that all coverage denials should be subject to the same rules to ensure consistency and clarity.

*Response:* The waiver of liability regulations govern all notices regarding noncovered hospital admissions. The significance of these admissions does not differ appreciably whether the hospital is a prospective payment hospital, a State reimbursement control system hospital, or some other type of hospital. In the case of prospective payment hospitals, special safeguards on continued stay denials are necessary, however, and have been provided by the regulations. These safeguards are necessary because a finding that a continued stay is not medically necessary (permitting charges to the beneficiary) does not usually result in a corresponding reduction in Medicare payment to the hospital. Hospitals paid under a State reimbursement control system would ordinarily be subject to the waiver of liability rules with respect to continued stay denials, but many hospitals have requested that the more stringent prospective payment system rules apply to these continued stay denials in order to provide a firm basis for the State to pay under Medicaid in appropriate circumstances for the lower level of care provided after the denial.

*Comment:* Some commenters were critical of our statement that we may consider precluding hospitals from charging for medically unnecessary services and custodial care if the hospitals continue to fail to comply with the notice requirements of § 412.42(c) regarding continued stay denials. The commenters recommended that we continue to work with the hospital industry through the PROs to educate providers when necessary, and correct these deficiencies on an individual basis, rather than arbitrarily penalizing the entire industry. They suggest that we should not only issue clarifying instructions on the notice requirements to the PROs, as has been done, but also communicate these instructions to the hospitals in the Hospital Manual.

*Response:* We have no intention of dealing with this problem by generally eliminating, without cause, the right of hospitals to bill for medically unnecessary and custodial care. As we noted in the NPRM, we believe that steps we have already taken to eliminate this problem are adequate. Furthermore, we hope that the increased consciousness of the hospital community will render this issue moot. We already have the regulatory authority to terminate provider agreements with hospitals that charge beneficiaries for covered care and can move now to deal with individual hospitals that bill inappropriately. As we noted in the NPRM, however, we will monitor this matter closely to assure that beneficiaries generally are not being misinformed or disadvantaged by hospitals and will take any other appropriate action to prevent this behavior.

*Comment:* One commenter stated that certain PROs and intermediaries have taken inappropriate actions to discourage hospital determinations of noncoverage. Allegedly, PROs have warned hospitals that, if they make a determination of noncoverage and charge the beneficiary, the beneficiary will be totally ineligible for inpatient Part A coverage for a period of 60 days following the date of discharge regardless of the medical necessity of any subsequent services. Additionally, the PROs are reported to have stated that even if a PRO is consulted on a medical necessity issue and concurs with the hospital, it reserves the right to reverse its own decision.

*Response:* If a PRO or intermediary made the statement that a determination of noncoverage could restrict the eligibility of a beneficiary for future Part A coverage, it gave completely erroneous information. A PRO could reverse its original concurrence with respect to a hospital finding of noncoverage on review, but this should rarely happen and then only on a finding that the original concurrence was on the basis of misinformation or the receipt of new and material evidence. We will look into these allegations of questionable actions by PROs and intermediaries.

*Comment:* A number of physicians, primarily radiologists, commented on the change in § 412.42(d)(4) that permits an attending physician to be among the individuals entitled to appeal an intermediary or PRO decision that certain diagnostic or therapeutic services were medically unnecessary. The commenters suggested that they, too, as physicians performing diagnostic testing on a referral basis, should have the right to appeal these denials because they have an interest in receiving payment for their services.

*Response:* We understand the concerns of these physicians; however, we do not believe that the right to appeal these denials should be extended to them. The services with which we are dealing here are hospital services, not physicians' services. The purpose of an appeal is to permit the interested party to demonstrate that there was a medical basis for providing or ordering the service in question. The hospital is given the right to appeal the decision because it furnished the service; the attending physician is given the right to appeal because he or she ordered the services. A referral physician, by definition does not establish the medical need for his or her service: the order of the attending physician is accepted. Therefore, there

is nothing for the referral physician to appeal.

If the Medicare claim from a physician who provided a service ordered by another physician is denied, the physician may bill and collect from the beneficiary, subject to the terms of the Medicare assignment agreement. On the other hand, if the referral physician submits a claim to Medicare for his or her own services, and the claim is denied because the services are found to be not medically necessasry, the physician has the right to appeal that decision.

3. Admission Pattern Monitoring (§ 412.45)

We proposed to delete § 412.45, which concerns admissions pattern monitoring, from the regulations because our operating experience with this type of review has led us to begin developing procedures that are more efficient and that use more current data than the data referred to in § 412.45.

*Comment:* Some commenters suggested that the revised procedures that we are developing for admission pattern monitoring should be included in a regulation that is published in the **Federal Register** with an opportunity for public comment.

*Response:* We believe that the commenters may have misunderstood our intent in deleting the specific procedural requirements of admission pattern monitoring from the regulations. The provisions we are deleting were written at a time when we did not have enough operational experience with the PRO program to identify the types of review and the intensity of review that were appropriate. Our experience has led us to understand that the volume of claims and review procedures to which the regulations bound us were not cost effective and to seek other, more current and focused means of achieving the desired result.

We agree with the commenters that review activities should be planned so that there is a minimum of wasted effort—either by PROs of by the hospitals. We believe that this effect is most effectively achieved by avoiding general prescriptive regulatory review formulas and relying, instead, on approaches to admission pattern monitoring that are data oriented and hospital-specific. Therefore, we have deleted this section from the regulations.

4. Other Medical Review Issues

Although we proposed no changes in the physician attestation requirements contained at § 412.46, we received a number of comments on them and we believe it is appropriate to clarify the policy here.

*Comment:* One commenter noted that some hospitals have or are installing automated medical records systems that do not involve the use of many paper documents and asked if the signature required under the physician attestation requirement could be an "electronic" one; that is, a computer code or other physician identifier.

*Response:* As we noted in previous documents (most recently in the August 31, 1984 final rule (49 FR 34735)), an actual signature is required under § 412.46. An electronic code will not suffice. It is critical that the physician's actual signature be submitted since the payment made is based on the information provided by the physician and the physician is liable for the correctness of the information.

*Comment:* One commenter objected to requirements, which are imposed by PROs, that the physician attestation statement be dated. The commmenter noted that the regulations requiring this attestation do not require that it be dated.

*Response:* Although the language at § 412.46(a) does not require a date, the regulations do require that the attestation statement be completed before a claim is submitted. We believe that a dated attestation is the most sensible method of demonstrating that this requirement has been met.

*D. Payment for Cost Outliers (§ 412.84)*

Under the prospective payment system, an additional payment is made to hospitals for a typical case known as "outliers." These are cases that have either an extremely long length of stay or extraordinarily high costs when compared to most discharges classified in the same DRG. A cost outlier case is a discharge that does not qualify as a day outlier case but in which covered charges adjusted to costs exceed the greater of a fixed dollar amount or a fixed multiple of the Federal prospective payment rate.

Currently, § 412.84 requires that, in the case of a cost outlier, the hospital must request medical review of all services furnished to the beneficiary. This medical review is performed before the additional amount requested by the hospital can be paid. Of course, if the medical review determines that some of the services are noncovered, the charges for those services will not be considered in determining if the claim meets the cost outlier threshold or the outlier payment amount.

We proposed to revise § 412.84 to provide that medical review prior to payment of cost outliers would not be required. However, if the PRO finds that a hospital has a pattern of inappropriately claiming these payments, the PRO could increase review of that hospital's claims, including review of all cost outlier cases for that hospital prior to payment. For cases in which payment is made for a cost outlier prior to medical review, the PRO would review a sample of these cases after payment. If the PRO determines that any services furnished in these cases are noncovered or inappropriately billed, the outlier payment for those services would be recovered from the hospital.

In addition to these changes, we would also revise § 412.84 to allow hospitals to request an outlier payment at the time they submit the bill for the discharge rather than waiting until they receive the intermediary's determination of the prospective payment rate for the discharge.

The majority of commenters were very much in favor of these proposed changes. However, the following issues were raised.

*Comment:* One commenter questioned whether the changes concerning review of cost outliers would revoke the intermediaries' current option of withholding the entire Medicare payment until the PRO has reviewed the claim.

*Response:* Under the revised regulations, intermediaries will no longer have an option for processing cost outlier cases. Except for claims from those hospitals placed on prepayment review by the PRO, the intermediary will process outlier claims just as it does any other claim under the prospective payment system. If cost outlier payment is requested with the initial submission of the bill, that payment will be included in the initial payment. The outlier portion of the payment is, of course, subject to recovery pending the outcome of any PRO review. If cost outlier payment is not requested in the hospital's initial submission of the bill, the basic DRG payment will be made and the hospital may request the additional outlier payment within 60 days.

Of course, if a hospital has demonstrated a pattern of inappropriate billing, the PRO may place the hospital under special review procedures. These procedures may include increased review of cost outlier cases or review of cases prior to payment. We expect that the need for prepayment review will occur infrequently.

*Comment:* One commenter believes that the new procedures would place a heavy burden on fiscal intermediaries

that may outweigh the benefits of such a change.

*Response:* We do not agree that the proposed changes would place a burden on the intermediaries. Day outlier payments prior to medical review have been authorized since January 1, 1984 (see the January 3, 1984 final rule (49 FR 311)). There has been little difficulty with this process and, therefore, we believe that there will be little difficulty in extending the policy to cost outliers. We will, however, continue to monitor the impact of this change closely in terms of administrative burden and program cost.

*Comment:* Commenters expressed concern that the sample level of cost outlier reviews currently prescribed in our administrative issuances is excessive in light of the low denial rate.

*Response:* The revised regulations deliberately do not define the sample size for review of cost outlier cases. They are intended to provide flexibility so that we may alter administratively the number of cases reviewed by the PRO as necessary. We have suggested that, at a minimum, 50 percent of cost outlier cases should be reviewed. However, PROs have the flexibility to review more claims from an individual hospital based on the hospital's past performance. We intend to continue to monitor denial rates in this area. If we believe it is appropriate to further reduce medical review of cost outliers, we will take action through our administrative issuance system.

*E. Referral Centers (§ 412.96)*

Hospitals may qualify as rural referral centers under three different approaches. Most hospitals qualify using the criteria set forth in § 412.96(c). One of the criteria that a hospital must meet under § 412.96(c) is that it has a case-mix index value that demonstrates the comparatively high degree of complexity of cases treated by the hospital. We believe a high case-mix index value helps to demonstrate the comparability of rural referral centers to urban hospitals in the same region. In the August 31, 1984 final rule, we set forth in § 405.476(g)(1)(iii)(A) (redesignated as § 412.96(c)(1)) four different case-mix index criteria, of which a hospital must meet at least one in order to qualify as a referral center for cost reporting periods beginning on or after October 1, 1984. These case-mix criteria are also factors against which a referral center is judged during its triennial review.

In the NPRM, we proposed to update the case-mix index values effective October 1, 1985 using the most current data we have available on case-mix. In addition, we proposed to revise § 412.96 so that, rather than state the actual criteria, it will describe the process we will use to calculate the case-mix indexes and will provide that we will publish the updated case-mix index values in the annual notices of prospective payment rates. These case-mix criteria would also be used during HCFA's triennial review to evaluate hospitals that are currently granted referral center status.

We proposed that, to qualify as a referral center for cost reporting periods beginning on or after October 1, 1985 under § 412.96(c)(1), a hospital's case-mix index during FY 1985 under the prospective payment system be at least—

- 1.1172; or
- Equal to the median urban case-mix index values calculated by HCFA for the census region in which the hospital is located as indicated in the table below.

| Region | Adjusted median urban case mix |
|---|---|
| 1 | 1.1443 |
| 2 | 1.1616 |
| 3 | 1.1226 |
| 4 | 1.1345 |
| 5 | 1.0955 |
| 6 | 1.1085 |
| 7 | 1.0542 |
| 8 | 1.1454 |
| 9 | 1.1638 |

For both the national case mix and median urban values, we multiplied the 1981 standards as published in the August 31, 1984 final rule (40 FR 34741) by 9.6 percent. This figure represented the percentage by which the average case-mix index value had increased from 1981 to bills processed through April 1985. The resulting figure was divided by 1.0105 to account for the reduction in the DRG relative weights for discharges occurring on or after October 1, 1984. (See the August 31, 1984 final rule (49 FR 34770) for a detailed discussion of this matter.) Thus, the proposed national case-mix criterion was computed as follows:

$$\frac{1.03 \times 1.096}{1.0105} = 1.1172$$

The same method was used to update the 1981 regional median urban case-mix index values.

In the NPRM, we also proposed to revise § 412.96(c)(2) to specify that we would publish the criteria for the number of discharges in each year's annual notice of prospective payment rates. However, we did not propose to update the number of discharges criteria applicable to cost reporting periods beginning in FY 1985 because we did not have current data available on total inpatient discharges for individual hospitals. Therefore, as proposed, the number of discharges criteria published in the August 31, 1984 final rule (49 FR 34741) would be used for FY 1986. In addition, we proposed to revise the title of § 412.96(b) (which provides alternative methods of qualifying for referral center status to those in § 412.96(c)) to indicate that these criteria apply to cost reporting periods that began on or after October 1, 1983, and that these criteria continue to apply in the future. We also made a technical change to § 412.96(f) to clarify the provisions of that paragraph.

*Comment:* One commenter stated that the current § 412.96(c) (which sets forth the criteria for cost reporting periods beginning in FY 1985) must be retained in the regulations. The commenter believes that this is necessary to distinguish between the criteria for cost reporting periods beginning on or after October 1, 1984 and ending before October 1, 1985 and the criteria effective for cost reporting periods beginning on or after October 1, 1985.

*Response:* We do not believe that this is necessary. The August 31, 1984 final rule specified that the alternative criteria published at § 405.476(g)(iii) (redesignated as § 412.96(c)) were effective for cost reporting periods beginning on or after October 1, 1984. The revised criteria set forth in this final rule are effective with cost reporting periods beginning on or after October 1, 1985. Thus, we believe the distinction between the earlier and revised sets of criteria and the periods to which they are applicable is clear. It has always been true for the most part that when dealing with the criteria applicable to a particular period of time, one must return to the regulations in effect at that time. Thus, we do not believe the commenter's suggestion is valid.

*Comment:* One commenter pointed out that the current criteria for rural referral center status, such as patient origin distance (that is, a certain percentage of patients treated at the hospital live more than a certain number of miles from the hospital) and case-mix indexes, do not adequately define rural referral centers The commenter believes that the types of special programs developed at referral centers should be the key characteristic considered.

*Response:* We believe that if we change the criteria as the commenter wishes, we would then be relying on

subjective rather than objective and numerical standards. In a program as large and complex as the Medicare program, we believe that reliance on subjective standards should be avoided.

Standards such as the types of special programs developed at referral centers would be very difficult to develop because almost any hospital can claim that it performs some type of service better than any other hospital in its vicinity. Even if these standards could be developed, each hospital that applies would then have to be reviewed—probably onsite—by a team of intermediary or HCFA personnel and physicians. Such a review would be very time-consuming and expensive.

Establishing numeric standards such as case-mix index and number of discharges permits us to determine with relative ease whether a facility qualifies for a particular exemption. These standards can be measured exactly and applied uniformly to all hospitals. Furthermore, objective standards are fairest to hospitals because the hospitals know in advance how the standards are derived and applied. Thus, we believe that it continues to be appropriate to rely on the objective standards set forth in the regulations.

*Comment:* One commenter recommended that service-specific criteria for referral centers be developed rather than arbitrary criteria based on a hospital's case-mix index or number of discharges. The commenter believes that service-specific criteria would better recognize the differences that exist between referral centers and other hospitals.

Another commenter suggested that a scope of services criterion be substituted for the case-mix index criterion. The suggestion was that the scope of services in the rural hospital should be compared to that offered by hospitals of comparable bed size in the surrounding urban areas. This commenter believes that objective criteria could be developed using American Hospital Association (AHA) listing of services or the number of the MDCs in which the hospital had Medicare discharges. For example, if a rural hospital had discharges in at least 17 of the 23 MDCs, then the case-mix index criterion would not have to be met, although the other criteria (that is, number of discharges and medical staff specialists) would still have to be met. This same commenter also suggested that a rural facility be designated as a rural referral center if it meets the scope of services criterion and it is located in a county that is at least 95 percent surrounded by areas designated as urban, even though it does not meet the case-mix criterion.

*Response:* We do not agree with the commenters' suggestions. As noted in the discussion of scope of services contained in the August 31, 1984 final rule (49 FR 34742), we believe that the criterion in § 412.96(c)(3) that at least 50 percent of a referral center's medical staff are specialists and the establishment of a case-mix index standard adequately address the scope of services measurement suggested by Congress in section 1886(d)(5)(c)(i) of the Act. In particular, we note that a high case-mix index value results from treating some of the sickest patients or patients that require complex services, and a hospital's ability to treat these patients generally means that it can furnish certain diagnostic and therapeutic services that are not readily available in most community hospitals. Any other potential standards, such as the AHA's Facility Codes or the MDCs, as suggested by commenters, would not, in our opinion, be as exact a measure of a hospital's devotion to treatment of the most ill patients as is the case-mix index standard.

The AHA uses over 50 Facility Codes that describe services and facilities available within each hospital. Some of these codes, such as abortion services and obstetrics, represent services that are used relatively infrequently by Medicare beneficiaries. Other codes, such as hospital auxiliary, volunteer services, and health promotion, are not relevant to a hospital's treatment of the sickest patients.

Similarly, we do not believe that using MDCs would be appropriate. Because the MDCs are based on organ systems of the body, the number of MDCs into which a hospital's patients are classified is, at best, a measure of the number of organ systems a hospital is prepared to treat. Since there are, in general, relatively low-weight and high-weight DRGs in virtually all of the MDCs, such a measure would not necessarily indicate that a hospital treats difficult or complex cases within an MDC. On the contrary, it is quite possible that a hospital could treat patients in the entire range of the MDCs but only those DRGs with low weights within each MDC, transferring to other hospitals all patients who would fall in the higher-weighted DRGs precisely because the hospital is not prepared to handle complex cases. Finally, we note that using a criterion based on the number of MDCs could adversely affect the status of specialty hospitals that are organized to treat patients in a relatively small number of MDCs and that, in light of their high degree of specialization, do serve as regional or national referral centers.

Scope of services would also be far more difficult to monitor than use of the case-mix index, which is easily determined and also used for other purposes. Comparison of a rural hospital's scope of services to the scope of services offered by urban hospitals of comparable size could be particularly subjective.

Section 1886(d)(5)(C)(i) of the Act states that a referral center should demonstrate that its characteristics are "similar to those of a typical urban hospital located in the same census region." In defining the characteristics of a typical urban hospital, we determined that comparable bed size was less relevant to a hospital's serving as a referral center than other characteristics. Accordingly, we developed criteria that rely on case-mix index and volume of discharges, using urban median values of both as a measure of typicality within each census region. (See the August 31, 1984 final rule (49 FR 34741).) In determining what a typical urban hospital would be, we believe that comparable size is less relevant than these characteristics. In addition, since rural counties are bounded by urban counties to varying degrees, some rural hospitals would be compared to only a few urban hospitals while others would be compared to many hospitals.

A commenter suggested that a rural hospital should be designated as a rural referral center under § 412.96(c) if it meets the scope of services, discharge, and medical specialist criteria, and if it is located in an area which is 95 percent or more surrounded by areas designated as urban. We have determined that there are approximately 30 hospitals in 12 counties that are substantially surrounded by urban areas or by bodies of water. In addition to this particular group of hospitals, we note that hospitals in numerous other rural counties similarly argue that they are like a neighboring county's urban hospitals and, therefore, ought to be deemed rural referral centers in order to be paid the urban rate. In our opinion, to permit these facilities to become rural referral centers without consideration of their case-mix index values would be inappropriate. The underlying principle of section 1886(d)(5)(C)(i) of the Act is that the hospitals that wish to be designated as rural referral centers must be able to demonstrate that they resemble typical urban hospitals, not that their geographic location is like an urban location.

We believe that the case-mix index is an important measure in determining a rural referral center's status because it measures the complexity of a hospital's cases and differentiates a true referral center from other rural hospitals. To substitute characteristics such as the percentage of the counties' boundaries on urban areas would undermine this important element in determining which hospitals qualify as rural referral centers.

*Comment:* One commenter objected to the inclusion of a number of discharges criterion. The commenter pointed out that in many rural communities one hospital may meet all of the criteria to qualify as a rural referral center, while another hospital in the same community cannot meet the volume of discharges criterion and, thus, is severely disadvantaged financially. Instead of making the discharge criterion mandatory, the commenter suggested that we look at the volume of discharges in a community rather than on an individual hospital basis, that we make the discharge criterion optional, or that we drop the concept of rural referral centers altogether.

*Response:* At the time the original prospective payment legislation was passed, there was no existing definition of referral centers. We therefore relied heavily on Congressional reports for guidance in defining the criteria for qualification for the rural referral center adjustment. Throughout congressional discussions, there were references to "large" facilities that treat "patients who require an intensity of resources beyond the capabilities of general community hospitals." Congress also referred to such centers as "large, technologically sophisticated hospitals" (129 *Cong. Rec.* S3224 (daily ed. March 17, 1983)). Thus, we determined that we should include a criterion to measure size. We considered other measures of size, such as bed size, but ruled them out because they do not necessarily reflect the number of patients treated by the hospital. We believe volume of discharges is the fairest and most accurate measure of size, an element that Congress clearly intended us to consider.

While we understand the difficulties inherent in one facility qualifying for the adjustment while a neighboring facility does not, we do not believe that these difficulties justify extending the provision to a hospital that clearly does not meet the current criteria. Regarding the alternatives offered by the commenter, we do not believe any are acceptable. Defining a community would be very difficult. Regardless of how the boundaries were established, there would be some hospitals just outside them that would be faced with the same difficulties that this commenter now faces; that is, that nearby hospitals are granted an adjustment while they are not. Also, we do not believe a community concept is in keeping with congressional intent. The law refers to "referral centers" and "hospitals"—not to communities.

The community concept could also result in some very small hospitals acquiring the adjustment by virtue of their proximity to a large hospital, or a very large hospital that meets the criteria not receiving the adjustment because of its location in a community with several very small hospitals. For example, if the discharge criterion for a community that has two hospitals was set at 10,000 discharges, and one hospital has 9,000 discharges and the other has 1,000, then both would qualify as referral centers. However, if one hospital had 7,000 discharges and the other has 2,500, then neither would qualify.

Finally, with regard to the commenter's suggestion that the entire concept of referral centers be eliminated, we do not have authority to do this. Although the concept of an adjustment for referral centers was not included in our original presentation of the prospective payment system to Congress, Congress did enact this provision and, therefore, we must implement it.

*Comment:* One commenter pointed out what appears to be a discrepancy in the proposed rule between the language on number of discharges in the preamble and the language in the regulations text. The preamble language stated (50 FR 24381), "Therefore, the criteria published in the August 31, 1984 final rule (49 FR 34741) would be used for FY 1986." The commenter believes that this means that a hospital that had 6000 discharges in 1981 could still meet the discharge criterion. However, § 412.96(c)(2) as presented in the proposed rule (50 FR 24388) states that "For the hospital's most recently completed cost reporting period, its number of discharges (excluding discharges from subprovider units and newborn units) is at least 6,000 . . . ."

*Response:* We agree that the language in the preamble could cause confusion and that it should have read "the number of discharges published in the August 31, 1984 final rule would be used for FY 1986." As proposed, a hospital seeking to qualify as a referral center for cost reporting periods beginning on or after October 1, 1985 must have had at least 6,000 discharges in its most recently completed cost reporting period, not in 1981, the time period specified in the current regulations.

*Comment:* Several hospitals wrote to protest the fact that we retained the original volume of discharges criteria while they claim that admissions have declined since 1981. One commenter specifically wanted the 1981 alternative retained; that is, a hospital would meet the discharge criteria in the future if it had 6,000 discharges in 1981.

*Response:* The 1981 standard was included originally because it was the last year for which we could accurately determine the total number of discharges for hospitals. We do not believe that continuing to permit a hospital to qualify forever based on 1981 experience is appropriate. The 1981 data are not relevant to a hospital's qualification for rural referral center status five or more years later.

We agree with the commenters' observation that there has been an overall decline in the number of discharges since 1981. However, as noted in the proposed rule, current data are not available on total inpatient discharges for individual hospitals (50 FR 24381). While sample data from the AHA's National Hospital Panel Survey for 1984 indicate that admissions have declined by about four percent nationally from 1981 through 1984, we do not yet have complete data on the distribution of this decline by type of hospital. It appears that much of this decline is related to efforts to shift certain kinds of cases to outpatient departments and other less resource-intensive settings. We believe that hospitals serving as referral centers, because they are organized to treat the sickest patients and the most complex cases, would be less able to shift patients to outpatient and other ambulatory care settings. Therefore, we have not revised the number of discharges criteria. The criteria published in the August 31, 1984 final rule (49 FR 34741) will be used for FY 1986. The national discharge criterion is 6,000 discharges in the most recently completed cost reporting period. The regional median urban discharges are set forth in the table below.

| Region | Urban discharges |
|---|---|
| 1 | 7,467 |
| 2 | 8,601 |
| 3 | 7,785 |
| 4 | 9,309 |
| 5 | 8,330 |
| 6 | 8,515 |
| 7 | 5,888 |

| Region | Urban discharges |
|---|---|
| 8 | 9,928 |
| 9 | 5,564 |

*Comment:* One commenter suggested that data from hospitals that offer highly complex and sophisticated care be deleted in determining the median urban case-mix index criterion. The commenter's rationale was that the urban benchmark becomes skewed when it includes case-mix data for large teaching hospitals, national referral centers, research centers, and other hospitals of this type. This commenter also questioned some of the wording in our discussion of the triennial review for hospitals other than those that failed to continue to meet the criteria for referral center in the first two years; specifically questioned is the meaning of "other situations" and experience in the first two years. Finally, the commenter claimed that the regulations were silent on the methodology and criteria to be used to conduct the triennial review.

*Response:* We do not agree with the commenter's suggestion concerning the median urban case-mix index values. In the first place, identifying these types of hospitals would be very difficult. Certainly, we could identify teaching facilities, but delineating research centers would be far more difficult since, to our knowledge, there are no existing, widely accepted definitions of these facilities. Use of these classifications is often by self-designation.

In its discussions of referral centers during passage of the original prospective payment legislation, Congress intended referral centers to be "large" facilities which treat "patients who require an intensity of resources beyond the capabilities of general community hospitals." (129 *Cong Rec* S3224–3226 (daily ed. March 17, 1983).) Congress also referred to these centers as "large, technologically sophisticated hospitals which serve as regional and national referral centers and which are characterized by high case mix indices, diverse geographical patient origin, and numerous multidisciplinary medical education programs." Thus, to delete the case-mix data of urban facilities of this type would be to delete data on the very type of facility that Congress envisioned as a rural referral center.

In fact, we could justify increasing the case-mix index value criterion by the percentage change in urban hospitals' average case mix, which would have been higher than the national average case-mix index increase, since rural referral centers are supposed to have characteristics similar to those of "typical" urban hospitals. We chose to use the national average case-mix index increase because it would be less disadvantageous to rural hospitals.

However, we have made two changes in the case-mix index criterion. The first is to apply the case-mix index criterion on a Federal fiscal year basis instead of a hospitals' cost reporting year basis. This will eliminate the need to recompute case-mix index values from data spanning two fiscal years using weights applicable to only one. Computation of hospitals case-mix index values spanning two Federal fiscal years requires estimates based on quarterly case-mix index values, which may disadvantage some hospitals seeking referral center status. Therefore, we believe a case-mix index value based on discharges occurring in a single Federal fiscal year will permit more precise and uniform application of the case-mix criterion.

Because the case-mix index criterion, which is based on a Federal fiscal year, is calculated for an earlier period of time than hospitals' cost reporting periods beginning during that fiscal year (except for October 1–September 30 cost reporting periods), we have also decided to update the criterion by the total national average case-mix index increase for discharges through the midpoint of the Federal fiscal year instead of through as much of the fiscal year for which we have case-mix index data. On the basis of hospital bills received in HCFA through July 1985 (FY 1985 discharges through March 1985), we have determined that the national average case-mix index increased by 10.8 percent since 1981. Using the same methodology as described in the proposed notice, we calculated the national case-mix criterion as follows:

$$\frac{1.03 \times 1.108}{1.0105} = 1.1294$$

Using the same formula applied to the census region, urban median case mix yields the following regional criteria:

| Region | Adjusted urban median case mix |
|---|---|
| 1 | 1.1568 |
| 2 | 1.1743 |
| 3 | 1.1349 |
| 4 | 1.1469 |
| 5 | 1.1075 |
| 6 | 1.1206 |
| 7 | 1.0658 |
| 8 | 1.1579 |
| 9 | 1.1765 |

These national and regional criteria figures replace those we announced in the proposed rule.

We note that the percentage increase used here to update the case-mix index criteria is higher than that used in the proposed notice, although the time period that the 10.8 percent case-mix index increase reflects is limited to FY 1985 through March 1985. The reason for this is the time lags between discharge date and receipt of bills in HCFA. In addition, the increase used in the proposed rule was based on case-mix increases using FY 1984 and FY 1985 bills, since we did not have a sufficient number of FY 1985 bills at that time to calculate a reliable estimate of FY 1985 case-mix increases relative to 1981. We now have sufficient data on FY 1985 discharges to calculate a reliable measure of case-mix increases.

Regarding the commenter's views on our discussion of how the triennial review will be conducted, we note that this was discussed in detail in the August 31, 1984 final rule (49 FR 34746). A reading of this section should clarify many of the commenter's concerns. "Other situations" refers to instances in which a hospital has met the criteria for either one or both of the first two years of its existence as a referral center. "Experience in the first two years" refers to whether or not the referral center met the criteria applicable to the periods in which it was classified as a rural referral center. Finally, both the methodology and the criteria to be used to conduct the evaluation are adequately defined in the proposed rule (50 FR 24380). Once a hospital meets rural referral center criteria based on prior experience, it will be paid at the urban rate for three years. In order to retain that status after the three years, it must continue to demonstrate that it meets the criteria.

The purpose of the triennial review is to assure that a hospital, having met the qualifying criteria to achieve referral center status based on a prior period, continues to resemble a typical urban hospital during at least two of the three years after it qualifies. Meeting the qualifying criteria does not automatically mean that a hospital will meet the retention criteria in its first year as a referral center. In order to meet the retention criteria, it must meet the same criteria for the same period as

other rural hospitals must meet to qualify for referral center status initially.

For example, if a hospital acquired rural referral center status anytime on or after October 1, 1984 and before October 1, 1985, it did so on the basis of criteria applicable to an earlier time period, such as 1981 or FY 1984. In order to retain referral center status upon triennial review, it will have to meet in its first year as a referral center the case-mix index, volume of discharges, and one of the optional criteria that are published effective October 1, 1985; that is, those published in this final rule. For its second and third years as a referral center, it will have to meet the criteria published in the annual notice of prospective payment rates that will set forth the rates effective for October 1, 1986 and October 1, 1987, respectively.

The following table demonstrates under which timeframes hospitals qualify for and continue to meet rural referral center status.

| Qualifying criteria | Period of referral center status—cost reporting period beginning in fiscal year | Mandatory retention criteria for triennial review |
|---|---|---|
| Criteria for cost reporting periods beginning in FY 1985 as published in the August 31, 1984 final rule. | 1985 | Case-mix index criteria for FY 1985 and discharges criteria for cost reporting periods beginning in FY 1985 as set forth in this final rule. |
| | 1986 | Case-mix index criteria for FY 1986 and discharges criteria for cost reporting periods beginning in FY 1986 as set forth in the final notice of prospective payment rates for FY 1987. |
| | 1987 | Case-mix index criteria for FY 1987 and discharges criteria for cost reporting periods beginning in FY 1987 as set forth in the final notice of prospective payment rates for 1988. |
| Criteria for cost reporting periods beginning in FY 1986 as set forth in this final rule. | 1986 | Case-mix index criteria for FY 1986 and discharges criteria for cost reporting periods beginning in FY 1986 as set forth in the final notice of prospective payment rates for FY 1987. |
| | 1987 | Case-mix index criteria for FY 1987 and discharges criteria for cost reporting periods beginning in FY 1987 as set forth in the final notice of prospective payment rates for 1988. |
| | 1988 | Case-mix index criteria for FY 1988 and discharges criteria for cost reporting periods beginning in FY 1988 as set forth in the final notice of prospective payment rates for FY 1989. |

The following examples using two rural hospitals with cost reporting periods beginning on January 1 help explain the above table:

*Example 1*

Hospital A had a 1981 case-mix index value of 1.08 and a discharge level of 7,000 in 1981. Because Hospital A also met one of the optional criteria, it qualified for rural referral center status beginning in January 1985 under the criteria published in the August 31, 1984 final rule. During the FY 1985 cost reporting period (that is, January 1–December 31, 1985), the hospital's case-mix index value rose to 1.13 and its discharges declined to 6,500. Since both of these criteria are higher than the minimum needed for qualification for FY 1986 (as set forth in this final rule), Hospital A meets the retention criteria for case mix and discharges for its first year of referral center status (assuming it continues to meet one of the optional criteria). The hospital's continued status as a referral center depends essentially on whether it meets the criteria for at least one more year in the following two years.

*Example 2*

Hospital B had a 1981 case-mix index value of 1.08 and a discharge level of 5,900 in 1981. Since it did not meet the discharge criterion, it could not qualify for referral center status beginning in January 1985. During its FY 1985 cost reporting period, Hospital B's case-mix index value rose to 1.13 and its discharges rose to 6,050. Since it will qualify under the criteria set forth in this final rule, Hospital B will be given referral center status beginning January 1, 1986 if it meets one of the optional criteria. It will keep referral center status at least three years. Hospital B's status as a referral center after that will depend essentially on whether or not it meets the criteria applicable to two of those three years.

*Comment:* One commenter stated that while our existing regulations do authorize additional payment for rural referral centers, they fail to acknowledge that urban hospitals may also serve as referral centers. The commenter requests that we review urban hospitals against the criteria to determine whether the hospital qualifies.

*Response:* The criteria in §412.96(b)(2) do apply to urban as well as rural hospitals. To our knowledge, only one urban hospital has applied under this section and its application was approved. However, we have not provided for any adjustment for this referral center because we have no data to show that an adjustment is warranted or justified.

*Comment:* One commenter believes that the rural referral center concept has been commingled with that of national and regional referral centers. The commenter would prefer that these two concepts be separated, as it is unlikely that most rural referral centers are analogous to the types of institutions described in the legislative history as national and regional referral centers.

*Response:* The original legislation that created that prospective payment system (Pub. L. 98–21) provided in section 1886(d)(5)(C)(i) of the Act that the Secretary take into account the special needs of regional and national referral centers (including those hospitals of 500 or more beds located in rural areas). The accompanying conference Committee report contained little clarifying language beyond the reference to very large acute care hospitals in rural areas. In our September 1, 1983 interim final regulations, we made a special payment provision for rural hospitals with 500 or more beds. We did not believe that other hospitals would need relief in the first year of the system when hospitals were receiving 75 percent of their payment based on their historical cost. In the January 3, 1984 final rule, we provided additional criteria for referral centers that apply to either urban or rural hospitals. These criteria depend upon referrals to the hospital by other hospitals and by physicians not on the hospital's staff, as well as the length of distance its Medicare patients traveled to receive care and the percentage of services furnished to those patients. We believe that these criteria were acceptable to Congress because the changes made to section 1886(d)(5)(C)(i) of the Act by section 2311(a) of Pub. L. 98–369 applied only to rural hospitals and that legislation did not add any new requirements for national and regional

referral centers. Thus, we have separate criteria for rural hospitals, as well as criteria that apply to urban as well as rural hospitals.

*Comment:* One commenter requested that we conduct an assessment to determine whether any payment adjustment should be made for urban hospitals, given the existence of the kinds of institutions described in the legislative history, the commenter believes that the absence of any adjustment other than that for rural referral centers slights the intent of this statutory provision.

*Response:* Until we obtain and review the cost data of urban hospitals under the prospective payment system, we cannot determine whether or not urban hospitals that meet the criteria for referral centers should receive any payment adjustment.

*Comment:* One commenter suggested that our criteria be revised to permit rural osteopathic hospitals to qualify for the rural referral center adjustment by lowering the volume of discharges criterion to 3000 a year. The commenter pointed out that osteopathic hospitals tend to be small and complex and draw their patients from outlying areas.

*Response:* We do not believe it would be equitable to single out one category of hospitals for special treatment. This would be unfair to other hospitals seeking the adjustment. In addition, it should be noted that a hospital can qualify as a rural referral center without regard to its number of discharges. Volume of discharges is not a consideration under § 412.96(b), although drawing patients from outlying areas (to which the commenter refers) is a criterion under that section.

*F. Indirect Medical Education (§ 412.118)*

Section 1886(d)(5)(B) of the Act provides that hospitals subject to the prospective payment system receive an additional payment for the indirect costs of medical education. The amount of this payment is based on a hospital's ratio of full-time equivalent interns and residents to bed size. The regulations governing this provision are found at § 412.118.

In our August 31, 1984 final rule, we revised § 412.118 (then § 405.477) based on the amendment made to section 1886(d)(5)(B) of the Act by section 2307(b) of Pub. L. 98-369. The amendment requires that, in determining the additional payment amount for indirect medical education, we must count interns and residents on the basis of where they furnish services, regardless of which entity (for example, hospital, university, or medical school) employs them. However, no intern or resident is counted as more than one full-time employee for any cost reporting period. (See the August 31, 1984 final rule for a detailed discussion of this revision (49 FR 34747).)

In the NPRM, we proposed to revise § 412.118 to change the way interns and residents are counted for purposes of making payment for indirect medical education costs effective with cost reporting periods beginning on or after October 1, 1984. Currently, § 412.118(e) provides that interns and residents must work 35 hours or more per week to be counted as one full-time employee. All interns and residents who do not meet this criterion are counted as one-half of a full-time employee. At present, we determine the additional payment amount based on the number of interns and residents employed during the last week of a hospital's cost reporting period. Therefore, if an intern or resident works for a hospital at least 35 hours per week for only a few weeks at the end of its cost reporting period, that individual is counted as a full-time employee for the entire cost reporting period.

Section 412.118(d)(2) currently requires that hospitals must submit a quarterly report to their fiscal intermediaries that includes, among other information, the actual hours worked by each intern and resident during each month. However, we believe that the 35-hour threshold is not reflective of the normal work week of interns and residents. Furthermore, the use of hours as a measure of intern of resident time requires substantial recordkeeping, and, if interns and residents rotate among several hospitals, a method of apportionment that is not necessarily consistent with reporting and counting for an institution's or program's scheduling purposes. We received numerous suggestions from hospitals that the policy be made easier to administer and require less paperwork.

Therefore, we proposed that the additional payment for indirect medical education costs for a hospital cost reporting period would be based on the number of interns and residents assigned to the hospital on September 1 during the hospital's cost reporting period. We also proposed that this method of counting interns and residents be retroactively applied to all hospital cost reporting periods beginning on or after October 1, 1984 (the date on which we implemented the system of reporting quarterly on intern and resident time). If we were to make the changes effective with cost reporting periods beginning on or after October 1, 1985, and not retroactive, hospitals would be required to implement one procedure for counting interns and residents effective on October 1, 1984 and another on October 1, 1985. This is a burden that we avoided by proposing to apply this rule retroactively.

For hospitals with cost reporting periods beginning on July 1, the same date that their graduate medical education programs begin, there would be a relatively stable number of interns and residents throughout the cost reporting period. However, in any other hospital, the cost reporting period would span more than one academic year. Thus, there could be significant fluctuation between the two years in the number of interns and residents to be counted. In these cases, we proposed to prorate the intern and resident counts for the two academic years based on the number of months of each academic year that fell into the cost reporting period.

Prior to October 1, 1984, hospitals were not required to keep schedules of assigned time or logs of actual time on which to base the intern and resident count. Therefore, for cost reporting periods beginning on or after October 1, 1984 and before July 1, 1985, we proposed to use April 15, 1985 instead of September 1, 1984 as the uniform reporting date.

Many interns and residents are assigned to freestanding family practice centers, hospital outpatient departments, and excluded units, such as psychiatric units. Currently, time spent in freestanding family practice centers and excluded units is not counted for purposes of the indirect medical education payment since these settings are not subject to the prospective payment system. Although we are currently counting time spent in outpatient departments, we proposed that time spent in these departments would not be counted for purposes of the indirect medical education payment because outpatient departments also are not subject to the prospective payment system and because the additional operating costs of outpatient departments associated with interns and residents are already recognized through reasonable cost reimbursement for hospital services furnished to outpatients.

Interns and residents assigned to areas of the hospital not subject to the prospective payment system would be counted based on where they are assigned on September 1. If an intern or resident is dividing his or her time on that day between these areas and the areas or units of a hospital subject to the

prospective payment system, the hospital would have to report to its intermediary the proportion of time spent in or assigned to both the included and excluded areas. The indirect medical education payment would be computed based on the proportion of time assigned to the areas of the hospital subject to the prospective payment system.

The additional payment for the indirect medical education costs is computed on the basis of the ratio of interns and residents to hospital bed size. Currently, for determining the intern and resident to bed ratio, as well as for classification purposes, a hospital's bed size has been determined based upon the total number of beds available on the first day of the pertinent cost reporting period. Since a hospital's bed size may increase or decrease, sometimes substantially, over the course of a cost reporting period, we proposed to base the number of beds on the number of available bed days (excluding beds assigned to newborns, custodial beds, and beds in excluded units) during the current cost reporting period divided by the number of days in the cost reporting period. We proposed that this change also be effective with cost reporting periods beginning on or after October 1, 1984.

We believe that a hospital's assignment of interns and residents on one day (September 1) would generally be representative of the academic year as a whole. However, it may be necessary for intermediaries to audit hospital records to verify the documentation of the September 1 assignments as reported to us and to verify that the September 1 count is representative of the count over the entire cost reporting period. Based on its review of the hospital's documentation, the intermediary may adjust the intern and resident to bed ratio for purposes of the final indirect medical education payment.

We received approximately 60 letters on this proposal from hospitals; hospital, physician, and other associations; a fiscal intermediary; and ProPAC. The commenters were generally in favor of the one-day count of interns, but were opposed to the exclusion from the count those interns and residents assigned to outpatient departments. The following are their specific concerns.

*Comment:* Some commenters have pointed out that in those years in which September 1 falls on a weekend or holiday, hospital staffing patterns may not be typical of their intern and resident assignments over the rest of the year. They suggest that we use the closest business day for the count in these years.

*Response:* We agree that in those years in which September 1 falls on a weekend or Labor Day, some hospitals may assign interns and residents in a different way than if September 1 were a typical business day. Therefore, we are revising the regulations to use a different date in these years. However, rather than use the closest business day, which in some cases will be at the end of August and at a time when hospitals may be changing their interns and resident assignments in preparation for the upcoming month, we will use the first business day following September 1.

*Comment:* One commenter gave an example of a residency program in which the count taken on September 1, 1985 would present a distorted picture of the distribution of interns and residents between two hospitals.

*Response:* Although we believe that for most hospitals, the September 1 date provides an accurate count of the intern and resident assignments throughout the year, we provided in the proposed rule that a hospital may provide additional information to the intermediary to demonstrate that the September 1 date is not representative. Similarly, intermediaries may audit hospital records to verify that September 1 represents the actual count of the assignments of interns and residents throughout the year. Based on the review, the intermediary may adjust the intern and resident to bed ratio.

*Comment:* One commenter stated that the proposal to count interns and residents as of September 1 each year will lead to distortions and uneconomic behavior on a given day of the year and lend the measurement to manipulation. The commenter suggested that since the 35-hour threshold did not reflect a normal work week of interns and residents, and since hospitals had to make quarterly reports to intermediaries anyway, it would be more appropriate to count as full-time each resident with 455 reported hours per quarter.

*Response:* We believe that this commenter misunderstood our proposal. The commenter's suggestion would continue to link payment to a 35-hour work week for interns and residents. Our proposal would revise our policy in which the count of interns and residents is made based on the number of hours in a work week. We believe that the one-day count is far superior to any methodology based on actual hours worked. Further, we believe that our proposal is less subject to manipulation than are the current procedures. There are a limited number of interns and residents during an academic year, and a one-day count should be reflective of the distribution of assignments through the year.

*Comment:* Commenters were concerned about the impact of using a single day approach to the counting of interns and residents for programs in which the number of these individuals varies widely from month to month. For example, two hospitals that share 20 residents who work approximately half the time in each hospital do not divide them on an equal basis each month. In one month there could be 15 at one hospital and 5 at the other. The commenters believe that this would lead to unequal payment to the hospitals if on September 1 the residents were not close to equally divided.

*Response:* Section 1886(d)(5)(B) of the Act requires that we establish a system of counting that does not distinguish on the basis of who employs an intern or resident and ensures that no intern or resident is counted as more than one full-time employee in any reporting period, regardless of the number of hospitals in which he or she works. We agree that the single day concept may not work in every possible situation. However, we do not believe that it is appropriate to impose substantial reporting requirements on all teaching hospitals, the majority of which appear satisfied with the single day count, in order to capture detailed data from the few for which a one day count is not representative. Therefore, we stated in the proposed rule (50 FR 24383) that hospitals could submit comprehensive data to show that the September 1 date is not typical of the entire cost reporting period.

We believe that the September 1 date meets the requirements of the law without skewing the results to the extent that there is a substantial adverse impact on any particualr facility. In previous years, we used September 30 as the single day for counting interns and residents (see the final notice of the schedule of limits on hospital per diem inpatient general routine operating costs published in the **Federal Register** on September 30, 1981 (46 FR 48010)), and it did not generate any adverse comment from the hospital industry. In considering a return to the single day approach, we worked with representatives of the hospital industry and took their comments and concerns into consideration.

*Comment:* One commenter indicated that the audit of hospital records to verify documentation of the September 1 assignments as to whether they are

representative of the entire cost reporting period defeats the purpose of the "single day" counting method; that is, to simplify recordkeeping while preserving the integrity of the count. The commenter suggests that examples should have been included to illustrate the nature of the intermediary's review. Finally, the commenter recommends that the proposal be dropped in favor of the current quarterly reporting system except that assigned time should be used instead of actual time in determining full-time equivalents. Other commenters indicated that the September 1 count might not be reflective of an individual's assignments over the course of the year, and that more documentation would be required such as residency program assignment schedules, intern and resident contracts, and payroll records.

*Response:* The "single day" approach to the counting of interns and residents is independent of the monitoring activity. We believe that in many cases, it will be clear that the count is accurate both for the date taken and for the year. This would be most apparent in the case of hospitals in which the number counted is less than the number of interns and residents who spend time in the facility, indicating that outpatient and excluded units assignments have been accounted for.

In the event the intermediary has reason to believe that the count of interns and residents is substantially in error for a particular facility, or if it is found upon audit that the facility may be counting interns and residents assigned to units reimbursed on a reasonable cost basis, the intermediary has the responsibility for reviewing hospital records and making any necessary changes in the count at the end of the cost reporting period. For purposes of the monitoring activity, hospitals are not being asked for any information not already in their records.

With respect to the inclusion in the preamble of examples to illustrate intermediary review activities, we believe that this information represents technical details that have an impact on implementation. Therefore, these examples should be included in policy guidelines issued through appropriate manual instructions for the purpose of implementing those regulations.

The August 31, 1984 final rule, which contained a provision for a quarterly reporting system, generally elicited negative reaction from the hospital industry. Many hospitals believe such a reporting system places an unnecessary recordkeeping burden on them. We agree with their stated concerns, and the regulations set forth in this document were written to simplify the recordkeeping activity accordingly. We believe that the new method for counting interns and residents takes into consideration individual rotations among hospitals and is consistent with reporting and counting for an institution's or program's scheduling purposes.

*Comment:* One commenter objected to the use of social security numbers as identifiers of interns and residents but did not object to the creation of another means of identifying interns and residents.

*Response:* The provision requiring the use of the social security number was contained in the regulations published in the August 31, 1984 final rule, and no negative comments were received. We do not believe that section 7 of the Privacy Act (U.S.C. 552a) is violated by withholding payment from hospitals that refuse to furnish social security numbers to intermediaries. No benefit is denied to an individual for failure to furnish the social security number. We would simply be denying an additional payment to a teaching hospital because it voluntarily decided not to furnish the information necessary to validate whether the payment is appropriate. We do not believe that the costs to Medicare involved in creating a whole new set of identifiers for interns and residents and the additional burden it would place on hospitals are justified.

*Comment:* Several commenters stated that the proposed rule did not clearly address how interns and residents are to be counted when they are assigned to ancillary departments, including operating rooms and radiology and laboratory departments. They pointed out that a percentage of the services provided in ancillary departments involve services for outpatients and inquired if the ancillary area's inpatient-outpatient allocation should be considered in the intern and resident count for adjustment purposes.

*Response:* Our position in the final rule is not to count interns and residents furnishing services to outpatients. Thus, interns and residents who treat outpatients or who furnish ancillary services to outpatients would not be counted for purposes of the indirect medical education adjustment.

Since the ancillary departments provide services to both outpatients and inpatients, we will determine the proportion of interns and residents who provide outpatient services on the basis of the ratio of outpatient charges to total charges in each ancillary department. While this approach does not necessarily reflect the precise way interns and residents spend their time in the ancillary departments, we believe it is a good approximation of the outpatient intern and resident count. This method also minimizes the recordkeeping activity of the hospital. If hospitals believe that the above methodology for apportioning interns and residents assigned to ancillary departments is inappropriate, they may provide additional information to their fiscal intermediary to document a more accurate apportionment.

*Comment:* One commenter asked how interns and residents who are on-call would be counted.

*Response:* Under the current regulations, the actual hours worked by interns and residents determined whether they were counted as full-time or one-half of a full-time employee. On-call time while an intern or resident was on the premises could make a difference in whether he or she was considered a part-time or a full-time equivalent. The new method of counting interns and residents based on their assignment to a hospital on September 1 eliminates the need to consider on-call time. If we were to count on-call time under the new rule, it would introduce a situation in which an intern or resident could be assigned to an excluded unit but on-call in another area of the hospital. Thus, he or she could be counted even if assigned to an excluded unit. To consider on-call time in situations such as this would defeat the intent of the regulations.

*Comment:* One commenter asked if dentistry and podiatry residents would be counted for purposes of the adjustment.

*Response:* At present, dentistry and podiatry residents are included in the count. However, we are reviewing this issue and, if we believe that a change in this policy should be made, we will propose that change in a future document published in the **Federal Register** for public comment.

*Comment:* One commenter believes that an intern or resident can account for more than one full-time equivalent. Also, the commenter questioned whether we have the authority to mandate the counting of interns and residents using one specific day in the reporting period.

*Response:* We believe it was Congress' intention, and our regulations at § 412.118 reflect that intent, that no intern or resident be counted as more than one full-time equivalent in any reporting period. This is true regardless of the number of hospitals in which he or she is providing services.

Previously, the "single day" approach was used for reporting the intern and resident count. Before publication of the

September 1, 1983 interim final rule, the single day for determining the count was September 30. The authority to establish the September 30 rule for counting interns and residents was never questioned by outside organizations or Congress.

*Comment:* Several commenters believe that we should count interns and residents in excluded units of the hospital, such as psychiatric and rehabilitation units, and in freestanding family practice centers outside the hospital setting.

*Response:* The indirect medical education adjustment recognizes that there are additional costs that teaching hospitals incur in connection with the presence of graduate medical education programs. Congress was concerned that teaching hospitals might be adversely affected by the implementation of the prospective payment system because these hidden costs would not be reflected in the prospective payment system payment rates as costs were standardized and the system moved toward a national payment rate applicable to all hospitals. Therefore, Congress authorized an additional payment representing those otherwise unidentified costs.

However, this rationale does not extend to excluded units or to freestanding family practice centers. Medicare continues to reimburse excluded units on a reasonable cost basis. The indirect costs of medical education are included in the overall costs of the unit upon which Medicare determines reasonable costs. Services furnished in freestanding clinics are payable on a Part B reasonable charge basis. The direct and indirect costs of operating the clinic are included in the charges made for services furnished there. In both cases, making an additional payment under the provisions of the indirect medical education adjustment to reflect the presence of interns and residents would be a duplicate payment.

*Comment:* One commenter indicated that it was inappropriate to reduce payment for indirect medical education costs without a careful analysis of the impact on availability of medical services in the communities that will be affected.

*Response*: We believe that the changes in the proposed regulation would have only a modest effect on the level of indirect payments to individual hospitals. Therefore, we do not think that our proposal would have a major impact on the availability of medical services in the affected communities.

*Comment*: Many commenters, in expressing concern over the proposal to exclude time that interns and residents spend in outpatient areas of hospitals in the calculation of the ratio of interns and residents to beds, pointed out that the proposal will be destructive to primary care specialty programs, which the Federal government has supported in the past. They also maintain that the proposal will encourage hospitals to assign interns and residents to inpatient areas of the hospital, that it will discourage the most cost-effective treatment of patients, and that it will remove an important source of funding for care furnished to uninsured patients.

*Response*: The additional payment to teaching hospitals for the indirect costs of graduate medical education programs was created because of the belief that these programs, by their very existence within institutions, increase the hospitals' costs in many ways. These indirect costs may include increased department overhead and the higher cost of treating patients due to a higher relative volume of laboratory tests and similar services.

In the September 1, 1983 interim final rule, the application of the indirect medical education payment was limited to hospitals that employed interns and residents who furnished services on their premises. Based on comments received, the rule was modified in the January 3, 1984 final rule to permit hospitals to count interns and residents employed by an organization with which the hospital had a longstanding relationship. The regulations were further modified in the August 31, 1984 final rule, based on enactment of section 2307 of Pub. L. 98–369, which precluded any consideration of who the employer of the interns and residents was in making these payments. Thus, this additional payment provision has been liberalized twice since the inception of the prospective payment system two years ago.

We believe that our proposal not to count interns and residents furnishing services to outpatients of the hospital is reasonable because outpatient services are not subject to the prospective payment system. Further, inclusion of interns and residents assigned to these areas is a misallocation of program resources since it means Medicare Part A funds are used to pay for services that are covered under Part B. Medicare continues to pay for outpatient services on a reasonable cost basis, and the indirect costs of the interns and residents providing these services are included in these payments. We believe that if this distinction is not made, Medicare will be making duplicate payments for indirect costs in the outpatient department.

We believe that the negative effects described by the commenters will not occur. It would be unfortunate if the decisions on whether to treat patients in the outpatient rather than inpatient setting were made strictly to promote the access of hospitals to additional Medicare payments. We continue to pay a great deal of the costs that hospitals that wish to promote primary care specialties incur for graduate medical education program.

*Comment*: Many commenters stated that we are required under section 1886(d)(5)(B) of the Act to count interns and residents furnishing services in outpatient settings because that section provides that the additional payment for the indirect costs of medical education be "computed in the same manner" as set forth in regulations in effect on January 1, 1983. They further argued that in the September 1, 1983 interim final rule we said that we would be counting interns and residents in hospital outpatient departments in order to avoid "altering only one element of the variable and failing to maintain comparability between the methodology used for developing the adjustment factors and subsequently standardizing hospital costs based on that factor" (48 FR 39778). Some commenters said that if interns and residents assigned to outpatient areas of the hospital are not counted on September 1, a new adjustment factor should be developed using the revised method of counting. A few commenters do not believe that these changes should be made retroactively.

Some commenters indicated that the indirect medical education adjustment was designed as a proxy for many cost factors that are difficult to quantify but are known to exist, that the financing of graduate medical education is extremely complex, and that certain medical specialty programs would be unfairly disadvantaged by our revision.

*Response:* We continue to believe that interns and residents who are not furnishing services to hospital outpatients should not be counted in determining additional payment to teaching hospitals for indirect medical education. We understand the concern of the commenters for the need to train interns and residents in primary care specialties, and we do not believe that hospitals will drop these programs solely because Medicare will not be paying for them under the indirect medical education adjustment.

It is important to note that Medicare, in fact, continues to pay for outpatient services on a reasonable cost basis, and these costs include the indirect costs of

services performed by interns and residents treating outpatients. Continuing to pay for them under the indirect medical education adjustment, while simultaneously paying on a reasonable cost basis, would pay for their indirect costs twice. Furthermore, since many interns and residents will be assigned to the outpatient setting on September 1 for only part of the day, their time spent furnishing services to inpatients on that day still will be computed in the indirect medical education ratio.

The commenters made two main arguments against our position. They cited language from the preamble of the September 1, 1983 interim final rule, in which we stated that we would not exclude interns and residents in outpatient departments in applying the factor because we would be altering only one element of the regression analysis on which it was based, with the result being that the amount of the adjustment would be incorrect. They also pointed out that section 1886(d)(5)(B) of the Act requires that the indirect medical education adjustment be computed "in the same manner as the adjustment" in effect on January 1, 1983.

In response to these comments, we first note that we are computing the adjustment "in the same manner" as previously, because we are basing it on the ratio of interns and residents to bed size. However, we do not believe that Congress intended that we ignore the fact that the stated rationale for the adjustment does not apply to outpatient services. There were no specific regulations in effect on January 1, 1983, although there was a description of the methodology to be used that was published in the final notice of the schedule of hospital cost limits for cost reporting periods beginning on or after October 1, 1982 that was published in the Federal Register on September 30, 1982 (47 FR 43310). We believe that Congress, in enacting the prospective payment system, intended that the methodology in effect be adopted rather than the entire description published in that notice. We also point out that in both the January 3, 1984 and August 31, 1984 final rules (the latter in response to the Congressional mandate in Pub. L. 98-369), we revised the methodology for counting interns and residents to adapt the previous system to the prospective payment system more effectively, yet we did not decrease the indirect medical education adjustment to reflect the larger number of interns and residents that hospitals were permitted to count. Therefore, the current adjustment itself is no longer entirely consistent with the original factor.

If the deletion of time furnishing services to outpatients, which decreases the count of interns and residents, invalidates the indirect medical education adjustment, it should follow that the expansion of programs that took place since the current factor was developed also should have invalidated the adjustment. However, especially since Congress did not mandate that the factor be recalculated, we believe that if there are, as here, overriding concerns, then revision to the method of counting interns and residents is justified. While a new regression analysis that takes into account the changes that have arisen since 1981 would be worthwhile, the cost data on which to base this are not yet available.

In the meantime, it has become apparent, since publication of the September 1, 1983 interim final rule, that even if it may cause some inconsistency with the regression analysis on which the current factor is based, exclusion of interns and residents furnishing services to outpatients is justified in light of the double counting that results from including these interns and residents. Moreover, since the ratio of intern and residents to beds has risen in most hospitals since 1981, even before the change in the August 31, 1984 final rule was fully implemented, we believe that the current adjustment, even without the adjustment factor being doubled, pays hospitals more than their actual indirect costs.

Finally, prior to the proposed rule, we defined a full-time employee as an intern or resident who worked 35 hours a week or more. Since most residents frequently work far more than this amount, the previous policy may have been justifiable as residents could have worked 35 hours or more treating patients in each of the settings, inpatient and outpatient. With the change to the one-day count, that policy no longer is appropriate.

However, we are going to make one change in response to the comments. We agree that it is inappropriate and contrary to what we said in the January 3, 1984 interim final rule (49 FR 268) to exclude interns and residents retroactively. Therefore, we are changing the proposed revision to § 412.118 to make the exclusion for interns and residents furnishing services to hospital outpatients effective with cost reporting periods beginning on or after October 1, 1985. By making this a prospective change, it will give teaching hospitals some time to plan for the impact of the change on their operations.

*Comment:* One commenter asked if interns' and residents' time spent in the outpatient department furnishing services to individuals admitted as inpatients before midnight of the next day could be included in the count. These individuals are considered hospital inpatients as of the day on which they are formally admitted as inpatients.

*Response:* If an individual is furnished outpatient hospital services and is thereafter admitted as an inpatient of the same hospital before midnight of the next day, the outpatient hospital services furnished to him or her are treated as inpatient services unless the patient does not have Part A coverage. Generally, for purposes of the indirect medical education adjustment, the time spent by interns and residents in the outpatient department is not counted regardless of the patient's status subsequent to treatment in the outpatient department. Consequently, there will generally be no allocation of interns' and residents' time to areas of the hospital covered under the prospective payment system due to this rule. However, if a hospital is able to furnish adequate documentation to its fascal intermediary concerning the percentage of Medicare beneficiaries treated in the outpatient department who are subsequently admitted to an inpatient area subject to prospective payment under this rule, the intermediary will use that percentage to apportion interns and residents assigned to the outpatient department back to the inpatient setting for purposes of the intern and resident-to-bed ratio.

*Comment:* One commenter indicated that time spent by interns and residents in outpatient departments is not comparable to time spent in freestanding centers or excluded units. The commenter pointed out that time in freestanding centers was excluded because they are not subject to Part A reimbursement, and that the time spent by interns and residents in excluded units must be excluded from the caluclation since the indirect costs are reimbursable on a cost basis. This policy would avoid duplicate payment of some of the costs. On the other hand, the indirect costs associated with time spent in outpatient departments were historically subject to cost reimbursement under Part A, and unlike the revised calculation resulting from excluded units, only residents' time, and not beds, would be removed from the calculation with a resultant distortion.

*Response:* We do not agree with the commenter. The situation regarding outpatient services is largely the same as that for excluded units. Both continue to be reimbursed on a reasonable cost basis (or charge basis in the case of freestanding centers), and these costs include indirect costs. The only difference between the two is that the removal of the excluded units from the adjustment affected bed size as well as the count of interns and residents. Bed size cannot change based on a different treatment of outpatient services since the historical Medicare definition of bed size is that it consists of beds (other than new born) maintained for inpatient use.

The indirect costs of graduate medical education activities associated with outpatient care are reimbursed on a reasonable cost basis under Part B. Including a count of interns and residents furnishing such care in the ratio of interns and residents to beds results in a duplication of payment of the indirect costs of the outpatient department.

*Comment:* One commenter believes that our proposal not to count interns and residents assigned to outpatient departments means that we are proposing to eliminate reimbursement for their services.

*Response:* The proposal applies only to the payment of an additional amount for the indirect costs of graduate medical education programs. The direct and indirect costs of operating these programs associated with the care of hospital outpatients will continue to be reimbursed on a reasonable cost basis. What we are proposing to eliminate is the duplicate payment for the indirect costs associated with interns and residents furnishing services to outpatients since these costs are included in the total cost for outpatient services.

*Comment:* One commenter requested a more precise definition of the term "available bed days."

*Response:* For purposes of the prospective payment system, "available beds" are generally defined as adult or pediatric beds (exclusive of newborn bassinets, beds in excluded units, and custodial beds that are clearly identifiable) maintained for lodging inpatients. Beds used for purposes other than inpatient lodging, beds certified as long-term, and temporary beds are not counted. If some of the hospital's wings or rooms on a floor are temporarily unoccupied, the beds in these areas are counted if they can be immediately opened and occupied.

*Comment:* One commenter suggested a change in the method of calculating the indirect medical education adjustment. Instead of using the ratio of interns and residents to beds, the commenter recommended that patient days would be used in lieu of available beds. The commenter believes that the use of patient days would not require an additional calculation, the data are readily available, and recommended a legislative change.

*Response:* As the commenter points out, this change would require legislation. Thus, we cannot change the regulations to meet this suggestion. However, as we obtain more data, we will consider this approach and others. If our analysis indicates that a change is necessary, we will propose a legislative amendment.

*G. Transfer Policy (§ 412.4)*

Our current policy concerning transfers between prospective payment hospitals provides for transferring hospitals to receive payment on a per diem basis. The discharging hospital receives the full DRG payment. Transferring hospitals may also receive an additional payment for extraordinarily high-cost cases that meet the cost outlier criteria in §§ 412.80 and 412.84; they are not eligible for day outlier payments.

As we have stated in previous prospective payment documents (most recently in the August 31, 1984 final rule (49 FR 34730)), our ultimate goal is to make one payment for the entire course of treatment. Because of the complexities of this issue, we did not propose any changes in the regulations that would implement a new transfer policy. However, we noted in the proposed rule that we are continuing to study this problem and to collect relevant data so that we can implement a single payment for transfers in the future.

Several commenters wrote to voice their opposition to the prospect of a single payment for transfer situations. Their specific objections are set forth below.

*Comment:* One commenter believes that a single payment policy would result in inequitable payments and operational problems.

*Response:* The prospective payment system is intended to provide full payment less applicable deductibles and coinsurance for all inpatient services associated with a particular episode of hospitalization. As we have previously stated on several occasions, our current transfer policy is an interim policy to be used until we restructure the payment methodology for making one payment to a hospital for the entire course of treatment. The single payment methodology will be developed only after we conduct a thorough review of the PATBILL file to evaluate the distribution of costs in a transfer situation. This review will enable us to develop a transfer payment policy that will be designed to result in equitable payments among hospitals and to limit administrative difficulties.

*Comment:* One commenter proposed that in transfer situations either full payment should be made to each hospital or the per diem method of payment should be continued. The commenter's greatest concern was that in no case should the transferring hospital or the discharging hospital be placed at risk for services furnished outside of its institution.

*Response:* We do not believe that full payment to the transferring hospital is appropriate in the majority of transfer situations. In multiple transfer situations in which the initial admitting hospital is also the ultimate discharging hospital, that hospital would receive two full payments—one for stabilizing the patient before transfer to the treatment facility and one for providing recuperative care before the patient is discharged. We agree that we should develop a methodology that allows the most appropriate payment to be made to hospitals for the medically necessary care furnished by each hospital in transfer situations. However, we do not believe that the solution lies in overpaying all hospitals involved to guarantee an adequate payment to the hospital that furnishes the bulk of a patient's care.

**V. Other ProPAC Recommendations**

As required by law, we reviewed the April 1, 1985 report submitted by ProPAC and gave its recommendations careful consideration in conjunction with the formulation of the proposals set forth in the NPRM. We received many comments on our treatment of the ProPAC recommendations. We have included these comments in our discussion of the issues to which they relate as they are set forth in the preamble and addendum to this final rule. Set forth below are the remaining ProPAC recommendations and the comments we received on them.

*A. Hospital Market Basket (Recommendations 2, 4 through 6, and 9)*

1. The Number of Market Baskets (Recommendation 2)

For FY 1986, ProPAC recommended using a single market basket for prospective payment system hospitals. However, it plans to study the

appropriateness of developing multiple market baskets by region and class of hospital.

We believe that this is an area that warrants further study and we support ProPAC's research. In the past, we have studied variations in regional market baskets and we plan to continue our research concerning multiple market baskets by region and class of hospital.

2. Market Basket Wage Component—Occupational Groups (Recommendation 4)

ProPAC recommended that separate wage categories by occupational groups should be created to take into account the broad changes in skill mix among managers, professionals, and other hospital workers. ProPAC suggested that changes in wages for these categories should be measured using a combination of internal and external proxy measures as follows:

- Managers and Administrators: The Employment Cost Index (ECI) for Managers and Administrators.
- Professionals and Technicians: A 50–50 blend of the Average Hourly Earnings (AHE) for the hospital industry and the ECI for Professionals and Technicians.
- Other Hospital Workers: A 50–50 blend of the AHE for the hospital industry and the ECI for all private industry.

The issue of whether to use only internal proxies as we do in formulating the current single wage component or a combination of internal and external (that is, hospital and nonhospital) proxy measures as ProPAC recommends has been debated for some time. We have opted to use internal proxies, since that position is consistent with our treatment of the wage index, which is also based on internal wage measures. Moreover, as ProPAC noted, the various external measures that might be used (including the ECI) also have certain drawbacks that we believe warrant further examination. We are studying this issue further and plan to develop various market basket models using internal and external proxies, as well as weighted occupational categories, for further consideration.

3. Employment Cost Index Feasibility Study (Recommendation 5)

ProPAC recommended that the Secretary should work with BLS to study the advantages and feasibility of developing an ECI for the hospital industry that includes both public and private hospitals and covers increases in both wages and fringe benefits.

The basic difference between an ECI and the AHE we currently use to measure increases in hospital workers' salaries is that the ECI controls for occupational mix. Therefore, the ECI would maintain the relative hospital worker skill mix constant over time and would preclude skill mix from affecting the amount of the increase in the hospital wage measure. We agree that this is an area that warrants further study and we plan to examine the merits of establishing an ECI for hospital workers as part of our ongoing analysis of the market basket.

4. Study Effects of Changes in the Minimum Wage Law on Hospital Workers (Recommendation 6)

ProPAC plans to study the extent to which hospital workers would be affected by changes in the Federal minimum wage law. The intent of the study is to detect whether, under the prospective payment system, workers who earn more than the minimum wages are differentially affected by statutory increases in the minimum wage compared with workers in other industries.

Since it is our desire that the prospective payment system be equitable, we would certainly want to know about any dimension of the system that is found to be unfair. However, we point out that the purpose of the prospective payment system is to develop prices for individuals DRGs. In accomplishing this, we have referred not only to wages paid to hospital workers, but to the entire spectrum of resources expended by hospitals in producing health care.

5. *Rebasing of Market Basket Weights (Recommendation 9)*

ProPAC suggested that the market basket weights should be rebased at least every five years or more frequently if significant changes in the weights occur. We agree that it is appropriate to periodically rebase the market basket weights in order to reflect more current data, especially if significant changes in the mix of inputs used by hospitals occur. We are currently in the process of developing rebased market basket weights. We also recognize that the market basket weights may require further revision to account for payment changes that might occur if additional costs, such as capital-related costs, are included in the prospective payment system.

*B. Hospital Labor Market Areas—Area Wage Index: Improvement of Labor Market Area Definitions (Recommendation 13)*

The current area wage index used to adjust payments for interarea wage differences does not distinguish separate labor markets within MSAs. ProPAC recommended that the prospective payment rates be adjusted to take into account variations in wages paid within a metropolitan area and in different rural locations within a State. ProPAC noted that several studies have shown that there is substantial variation in the wages paid in the inner city as compared with suburban areas (that is, "core" areas and "ring" areas) within the same MSA and that similar concern has been expressed regarding rural areas within a State.

ProPAC recommended that these differences in hospital labor markets be reflected in the application of the area wage index used to adjust the prospective payment rates for actual variation in area wage levels. While ProPAC recommended that labor market area definitions be improved to better reflect hospital labor market areas, the report did not discuss how specific alternatives to the current MSA/non-MSA definitions might be established.

We have previously acknowledged in various Federal Register documents that the current MSA/non-MSA definitions may not adequately recognize widely varying hospital labor market conditions, especially among counties classified as rural. We have been looking into possible alternative classification systems that would better define hospital labor markets. The core-ring concept for splitting MSAs that is addressed in ProPAC's recommendation is one alternative that we have previously considered (see the January 3, 1984 final rule (49 FR 254)). In addition, we are studing other classification systems such as the Department of Commerce's Bureau of Economic Analysis (BEA) economic areas that are defined based on area ties to economic centers.

However, we believe that extensive research and study will be required before alternative labor market definitions are adopted. As with any classification system in which boundaries must be established, it is impossible to designate boundaries that will be completely satisfactory to all concerned. Therefore, we must be certain that any new classification system is based on objective criteria that will provide more equitable labor market area definitions than the current MSA/non-MSA classifications.

*Comment:* One commenter was in favor of our using the BEA economic areas to establish whether a hospital is located in an urban or rural area.

*Response:* Section 1886(d)(2)(D) of the Act defines an urban area as an area

within an MSA as designated by EOMB or within a similar area, as we recognized under the regulations (§ 405.460) establishing limits on total inpatient operating costs under section 1886(b) of the Act. We have begun preliminary analysis of the suitability of using BEA economic areas for area wage index classification purposes. However, more thorough analysis will have to be performed to determine whether these areas are more or less appropriate than MSAs for defining hospitals' labor market areas.

As we move closer to a national standardized amount for the prospective payment system, we are continuing to evaluate the necessity of establishing separate national urban and rural rates. In addition, Congress has requested a study on the feasibility and impact of eliminating or phasing out separate urban and rural classifications.

*Comment:* Commenters requested that an adjustment be provided for hospitals located in rural areas where the residents commute to more than one nearby MSA. Under current EOMB guidelines, a county is included in an MSA if a certain percentage of the county's resident population commutes to the MSA. However, the commenters point out that if the same percentage of residents of a county commute to more than one MSA, the county is not included in any MSA. The commenters believe that a county such as this should be designated as an urban county rather than rural and the wage index value assigned to it should be the value of the MSA to which the greatest number of persons commutes.

*Response:* As we noted above, for purposes of the prospective payment system, section 1886(d)(2)(D) of the Act defines an urban area as an area within an MSA as designated by EOMB or within a similar area, as recognized under the regulations (§ 405.460) establishing limits on total inpatient operating costs under section 1886(a) of the Act. The designation of a county as urban or rural is based on whether or not a particular location qualifies as an MSA or New England County Metropolitan Area (NECMA). The criteria for MSA or NECMA status are not within our control. EOMB determines which areas qualify as MSAs or NECMAs and the effective date of their qualification based on standards prepared by the Federal Committee on MSAs, which advises EOMB on metropolitan area definitions.

We are not aware of any criteria that are as objective as the MSA criteria are for use in determining whether a hospital is located in an urban or rural area. We do not believe it would be appropriate to establish criteria in our regulations that have been derived solely to allow a targeted hospital or group of hospitals to be classified as urban. On the contrary, we believe that the criteria we establish should have broad applicability and serve to delineate common characteristics that objectively define urban and rural areas.

*Comment:* A commenter indicated that hospitals located in the same MSA but not the same census division should all be assigned to the same census division.

*Response:* We addressed this situation in the August 31, 1984 final rule (49 FR 39738). Section 1886(d)(2) of the Act authorizes us to deem a hospital to be located in the region in which the largest number of hospitals in the same MSA are located or the largest number of discharges occur. We elected to assign a hospital in an MSA or NECMA that crosses two or more census divisions to the census division in which most of the MSA's or NECMA's hospitals are located (§ 412.62(f)(2)). These regulations were effective for cost reporting periods beginning on or after October 1, 1983. We believe that the current regulations address the problem of hospitals in the same MSA that are located in different census regions and do not plan to revise them.

### *C. Hospitals Serving Disproportionate Shares of Low Income or Medicare Patients (Recommendations 14 and 15)*

ProPAC recommends that an adjustment be established for FY 1986 rates for hospitals that serve a disproportionate share of low income or Medicare patients or both and that a definition of these hospitals be established based on a broader concept of low income than simply percentage of Medicaid patients. However, ProPAC made no specific recommendation as to the basis for such an adjustment.

As required by section 2315(h) of Pub. L. 98-369, we have been working on the development of the definition. However, as discussed more thoroughly in the proposed rule (50 FR 24384), our research efforts have been hampered by the lack of data of sufficient quality to permit us to develop a definition with any degree of confidence.

Once we obtain accurate data, we will be able to turn our attention to analyzing whether, in fact, hospitals serving a significantly disproportionate number of low income or Part A Medicare patients experience higher Medicare costs per case due to the provision of care to these patients or whether these additional costs are accounted for by severity, inefficiency, or other factors. We will then determine whether these costs are already appropriately recognized in the prospective payment system or if additional payment adjustments should be made.

*Comment:* Numerous commenters expressed their belief that an adjustment should be provided to hospitals serving a disproportionate share of low income or Medicare Part A patients.

*Response:* As we explained in the proposed rule, we do not have conclusive evidence to date that warrants an adjustment for hospitals serving a significantly disproportionate share of low income or Medicare Part A patients. A disproportionate share adjustment must be firmly rooted in an analytical research model that accurately depicts the relationship between high proportion of low income patients and a hospital's average Medicare costs. Currently, no model exists.

The present methodology assumes that all hospitals serve an average proportion of low-income or Medicare Part A patients. Implementing a national adjustment would arbitrarily select one definition of a disproportionate share hospital and reward only those hospitals that conform to the arbitrary definition. The selection of hospitals and the magnitude of any adjustment are critical because the funds to pay for the significantly disproportionate share adjustment would likely come from lowering the standardized Federal rates to exclude from the base those costs associated with treating a disproportionate share of low income or Medicare Part A patients. If an analysis shows that hospitals with a high percentage of low-income or Medicare Part A patients are being underpaid, then hospitals with low levels of these types of patients must be overpaid. An arbitrary national adjustment would only create a new set of payment inequities among hospitals.

As mentioned in the proposed rule, we are continuing to review the feasibility of using Medicare patient origin data and census data on the aged with income below the poverty level to assess the impact of low-income Medicare patients on hospital costs. We are also continuing to investigate an alternative proxy for low income other than "percent Medicaid" that will be more reliable than the data we obtained from the Office of Civil Rights (OCR) survey. At this time, the relationship between Medicare costs and low income patients is not well understood even though research done by the Congressional Budget Office, ProPAC,

and HCFA indicates that hospitals with a high percentage of Medicaid patients tend to have higher average Medicare costs.

Recently, we have obtained survey data from the AHA on hospitals' Medicare and Medicaid utilization information. The AHA data base is also somewhat flawed because the data are self-reported on a voluntary basis and unaudited. In addition, data are missing for about 20 percent of the hospitals. Through analysis of this information on Medicare and Medicaid utilization, we will try to determine if hospitals that serve a significantly disproportionate share of low-income patients or Medicare Part A patients have different average Medicare inpatient costs due to the provision of care to these patients or if these additional costs are accounted for by severity, inefficiency, or other factors.

In addition, ProPAC recently compiled information that demonstrated the range of Medicaid coverage of the population below the poverty level in 1979. The data ranged from a high of 143 percent in Massachusetts to a low of 25 percent in Texas. These results lead us to question the assumption that percent of Medicaid utilization has a consistent relationship to low income. We recognize the importance of this issue and are committed to continuing the search for realistic policy options. Only with some further analysis will we be able to determine if inpatient costs associated with the treatment of low income patients are already appropriately recognized in the prospective payment system or if additional payment adjustments should be made.

## VI. Summary of Changes

For the convenience of the reader, we are summarizing the changes we are making to the regulations. The reader is referred to the detailed discussions above for an explanation of the rationale for these changes.

### *A. Rate of Increase Limits*

We are revising § 405.463 to—

- Provide that the applicable target rate percentage is the prospectively determined percentage, published by HCFA, based on the estimated market basket index for the calendar year adjusted by other factors as determined by the Secretary: and
- Delete the October 1, 1985 expiration date for the exemption from the rate of increase limit that is available to new hospitals.

### *B. Changes in the DRG Classification System*

We are adding a new § 412.10 that describes the procedures we will use to revise the DRG classification system both annually and, on a very limited basis, during the Federal fiscal year.

In response to comments, we have revised our proposed § 412.10 to provide that any interim changes made because of a serious omission or inequity in the DRG classification system will be published as a final notice with comment period in the Federal Register. Changes made to incorporate a newly covered service or item will be issued through our administrative issuance system as we proposed. Both of these changes will be included in the next annual notice of changes to the DRG classification system, which we hope to publish early each year. We also added a provision describing ProPAC review of interim changes.

### *C. Exclusion of Alcohol/Drug Hospitals and Units*

In §§ 421.23(c) and 412.32, we are changing the expiration of the qualifying date of the exclusion for alcohol/drug hospitals and units from October 1, 1985 to the end of the hospital's cost reporting period beginning before October 1, 1985. In response to comments, we have decided to extend the exclusion for one more year for those units and hospitals who currently qualify for an exclusion.

### *D. Review Activities*

We are making changes in Subparts C and F of 42 CFR Part 412 to replace all references to PSROs and medical review entities with references to PROs because the PROs are now fully operational. In addition, we are deleting § 412.45, which describes how we monitor discharge rates under the prospective payment system.

### *E. Charges to Beneficiaries*

We are adding a new § 405.308 that allows hospitals excluded from the prospective payment system because of their participation in a State reimbursement control system or demonstration project to change beneficiaries for custodial or medically unnecessary care after issuing the proper notices that are currently required in § 412.42(c) for prospective payment hospitals.

### *F. Payment for Cost Outliers*

We are revising § 412.84 to delete the requirement that all cost outlier cases must be reviewed by the PRO before payment. However, these cases could be subject to prepayment review if the hospital demonstrates a pattern of inappropriate billing. The PRO will also review a sample of the claims that were not reviewed prior to payment. If, as a result of its postpayment review, the PRO determines that any services were noncovered, the outlier payment will be recovered from the hospital. We are also revising § 412.84 to allow hospitals to request cost outlier payment at the time they submit bills for payment, rather than waiting until after the intermediary has notified them of its determination on payment for the discharge.

### *G. Referral Centers*

We have revised § 412.96 as follows:

- The title of pargraph (b) is changed to indicate that this paragraph is effective for cost reporting periods beginning on or after October 1, 1983.
- Paragraphs (c)(1) and (c)(2) are revised to provide that the criteria related to case-mix index and discharges for referral centers will be published in the proposed and final annual prospective payment rate notices.
- We added a new paragraph to describe the method we will use to calculate updated case-mix indexes each year.

### *H. Indirect Medical Education*

We are revising § 412.118 effective for cost reporting periods beginning on or after October 1, 1984 as follows:

- Change the method used to determine the number of beds in a hospital for purposes of counting interns and residents.
- Delete the requirement of a quarterly report from hospitals on numbers of interns and residents and replace it with an annual report that counts by specialty the number of interns and residents on September 1 (with an additional count on April 15, 1985 for hospitals with cost reporting periods beginning on or after October 1, 1984 and before July 1, 1985). In response to comments, we added a provision that requires the count to be made on the next business day after September 1 when that day falls on a weekend or Federal holiday.
- Delete the requirement of counting hours of interns and residents to determine full-time equivalents. Instead, all interns and residents assigned to the hospital on September 1 (or April 15, 1985, if applicable) will be counted as full-time except for those individuals splitting their time between prospective payment areas and one or more areas excluded from the prospective payment system or spending all their time in the excluded areas. In response to

comments, we have delayed until cost reporting periods beginning on or after October 1, 1985 implementation of our decision to no longer count interns and residents furnishing services to outpatients as full-time.

• Provide for intermediary review of hospital documentation to verify the hospital's intern and resident-to-bed ratio.

**VII. Other Required Information**

*A. Effective Dates*

The effective date of the final rule (including the addendum and appendix) is October 1, 1985. Changes to the regulations are effective as follows:

October 1, 1985

§§ 405.301 and 405.308—Charges to beneficiaries.

§ 405.463—Rate of increase limits.

§ 412.10—Changes to the DRG classification system.

§§ 412.23 and 412.32—Exclusion of alcohol/drug hospitals and units.

§§ 412.42, 412.44, 412.45, and 412.48—PRO medical review.

Effective With Discharges Occurring on or After October 1, 1985

§ 412.84—Payment for cost outliers.

Effective With Cost Reporting Periods Beginning on or After October 1, 1984

§ 412.118—The changes affecting the indirect medical education adjustment factor are all effective with cost reporting periods beginning on or after October 1, 1984 except that the provision under which interns' and residents' services to outpatients will no longer be counted for purposes of the adjustment factor is effective with cost reporting periods beginning on or after October 1, 1985.

Effective With Cost Reporting Periods Beginning on or After October 1, 1985

§ 412.76—Referral centers.

§ 412.118—Count of interns' and residents' services to outpatients.

*B. Paperwork Reduction Act*

Section 412.118 of this final rule contains information collection requirements that are subject to review by EOMB under the authority of the Paperwork Reduction Act of 1980 (44 U.S.C. 3501–3511). A notice will be published in the **Federal Register** when approval is obtained. Organizations and individuals who wish to submit comments on the information collection requirements should direct those comments to the agency official whose name appears in the preamble and to the Office of Information and Regulatory Affairs, OMB, New Executive Office Building (Room 3208), Washington, DC, 20503, Attention: Fay Iudicello.

**List of Subjects**

*42 CFR Part 405*

Administrative practice and procedure, Health facilities, Health maintenance organizations (HMO), Health professions, Kidney diseases, Laboratories, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

*42 CFR Part 412*

Cancer hospitals, Christian Science Sanatoria, Discharges and transfers, Inpatient hospital services, Medicare, Outlier cases, Prospective payment, Referral centers, Renal transplantation centers, Sole community hospitals.

*C. Impact Analyses*

The appendix to this final rule, which is printed immediately following the addendum to this final rule, sets forth our analyses of the projected impact and effect on small businesses of the changes that are set forth in this document.

42 CFR Chapter IV, Subchapter B is amended as set forth below:

## CHAPTER IV—HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

### SUBCHAPTER B—MEDICARE PROGRAMS

I. Part 405 is amended as follows:

## PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

A. Subpart C is amended as follows:

### Subpart C—Exclusions, Recovery of Overpayment, Liability of a Certifying Officer and Suspension of Payment

1. The authority citation for Subpart C continues to read as follows:

**Authority:** Secs. 1102, 1154(a)(2)(B), 1815, 1833, 1842, 1862, 1866, 1870, 1871, and 1879 of the Social Security Act (42 U.S.C. 1302, 1320c–3(a)(2)(B), 1395g, 1395l, 1395u, 1395y, 1395cc, 1395gg, 1395hh, 1395pp), and 31 U.S.C. 3711.

2. The table of contents of Subpart C is amended by adding the title of a new § 405.308 to read as follows:

**Subpart C—Exclusions, Recovery of Overpayment, Liability of a Certifying Officer and Suspension of Payment**

* * * * *

Sec.

405.308 Limitations on charges to beneficiaries.

* * * * *

**§ 405.301 [Amended].**

3. Section 405.301 is amended by revising the citation "405.310" to read "405.308".

4. A new § 405.308 is added to read as follows:

**§ 405.308 Limitation on charges to beneficiaries.**

(a) *Prospective payment hospitals.* A hospital receiving payment under the prospective payment system for a covered hospital stay may charge a beneficiary for items and services excluded from coverage only as described in § 412.42 of this chapter.

(b) *Hospitals participating in State reimbursement control systems or demonstration projects.* A hospital receiving payment for a covered hospital stay under either a State reimbursement control system approved under 1886(c) of the Act or a demonstration project authorized under section 402(a) of Pub. L. 90–248 (42 U.S.C. 1395b–1) or section 222(a) of Pub. L. 92–603 (42 U.S.C. 1395b–1 (note)) and that would otherwise be subject to the prospective payment system may charge a beneficiary for noncovered services as follows:

(1) For the custodial care and medically unnecessary services described in § 412.42(c) of this chapter, after the conditions of § 412.42 (c)(1) through (c)(4) are met; and

(2) For all other services in accordance with the applicable rules described in Part 489 of this chapter.

B. Subpart D is amended as follows:

### Subpart D—Principles of Reimbursement for Providers, Outpatient Maintenance Dialysis, and Services By Hospital-Based Physicians

1. The authority citation for Subpart D continues to read as follows:

**Authority:** Secs. 1102, 1814(b), 1815, 1833(a), 1861(v), 1871, 1881, 1886, and 1887 of the Social Security Act as amended (42 U.S.C. 1302, 1395f(b), 1395g, 1395l(a), 1935x(v), 1395hh, 1395rr, 1395ww, and 1395xx).

2. Section 405.463 is amended by revising paragraphs (c)(3)(i) and (f)(1) to read as follows

**§ 405.463 Ceiling on rate of hospital cost increases.**

* * * * *

(c) *Procedure for establishing the ceiling (target amount).* * * *

(3) *Target rate percentage.* (i) The applicable target rate percentage will be the prospectively determined percentage, published by HCFA, based on the estimated increase in the market basket index for the calendar year

adjusted by other factors as determined by the Secretary.

* * * * *

(f) *Exemptions*—(1) *New hospitals.* New hospitals that request and receive an exemption from HCFA are not subject to the rate of increase ceiling imposed under this section. For purposes of this section, a new hospital is a provider of inpatient hospital services that has operated as the type of hospital for which HCFA granted it approval to participate in the Medicare program, under present or previous ownership, or both, for less than three full years. This exemption expires at the end of the first cost reporting period beginning at least two years after the hospital accepts its first patient.

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II. Part 412 is amended as follows:

## PART 412—PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT HOSPITAL SERVICES

A. The authority citation for Part 412 continues to read as follows:

**Authority:** Secs. 1102, 1871, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395hh, 1395ww).

B. The table of contents of Part 412 is amended by adding the title of a new § 412.10 to Subpart A and deleting the title of § 412.45 from Subpart C to read as follows:

**Subpart A—General Provisions**

Sec.

* * * * *

412.10 Changes in the DRG classification system.

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C. A new § 412.10 is added to Subpart A to read as follows:

### Subpart A—General Provisions

**§ 412.10 Changes in the DRG classification system.**

(a) *General rule.* HCFA issues changes in the DRG classification system in an annual notice. Except as specified in paragraphs (c) and (d) of this section, the DRG changes will be effective prospectively with discharges occurring on or after the same date the payment rates are effective.

(b) *Basis for changes in the DRG classification system.* All changes in the DRG classification system are made using the principles established for the DRG system. This means that cases are classified so each DRG is—

(1) Clinically coherent; and

(2) Embraces an acceptable range of resource consumption.

(c) *Interim coverage changes*—(1) *Criteria.* HCFA makes interim changes to the DRG classification system during the Federal fiscal year to incorporate items and services newly covered under Medicare.

(2) *Implementation and effective date.* HCFA issues interim coverage changes through its administrative issuance system and makes the change effective as soon as is administratively feasible.

(3) *Publication for comment.* HCFA publishes any change made under paragraph (c)(1) of this section in the next annual notice of changes to the DRG classification system published in accordance with paragraph (a) of this section.

(d) *Interim changes to correct omissions and inequities*—(1) *Criteria.* HCFA makes interim changes to the DRG classification system to correct a serious omission or inequity in the system only if failure to make the changes would have—

(i) A potentially substantial adverse impact on the health and safety of beneficiaries; or

(ii) A significant and unwarranted fiscal impact on hospitals or the Medicare program.

(2) *Publication and effective date.* HCFA publishes these changes in the **Federal Register** in a final notice with comment period with a prospective effective date. The change is also published for public information in the next annual notice of changes to the DRG classification system published in accordance with paragraph (a) of this section.

(e) *Review by ProPac.* Changes published annually in accordance with paragraph (a) of this section are subject to review and comment by ProPac upon publication. Interim changes to the DRG classification system that are made in accordance with paragraphs (c) and (d) of this section are subject to review by ProPac before implementation.

D. Subpart B is amended as follows:

### Subpart B—Hospital Services Subject to and Excluded From the Prospective Payment System

1. In § 412.23, the introductory language in paragraph (c) is revised to read as follows:

**§ 412.23 Excluded hospitals: Classifications.**

* * * * *

(c) *Alcohol/drug hospitals.* If an alcohol/drug hospital meets the following requirements, it is excluded from the prospective payment system for its cost reporting periods beginning before October 1, 1986, but no hospital is excluded for its cost reporting period beginning during Federal fiscal year 1986 unless it was excluded for its cost reporting period beginning during Federal fiscal year 1985:

* * * * *

2. In § 412.32, the introductory language is revised to read as follows:

**§ 412.32 Distinct part alcohol/drug units: Additional requirements.**

If a distinct part alcohol/drug unit meets the following requirements, it is excluded from the prospective payment system for its cost reporting periods beginning before October 1, 1986, but no unit is excluded for its cost reporting period beginning during Federal fiscal year 1986 unless it was excluded for its cost reporting period beginning in Federal fiscal year 1985:

* * * * *

E. Subpart C is amended as follows:

### Subpart C—Conditions for Payment Under the Prospective Payment System

1. In Subpart C, all occurrences of the phrase "medical review entity" are revised to read "PRO".

2. In § 412.42, the introductory language of paragraphs (c) and (c)(3) is reprinted for the convenience of the reader; paragraphs (c)(2) and (c)(3)(iv) are revised; the introductory language of paragraph (d) is reprinted for the convenience of the reader; and paragraphs (d)(3) and (d)(4) are revised to read as follows:

**§ 412.42 Limitations on charges to beneficiaries.**

* * * * *

(c) *Custodial care and medically unnecessary inpatient hospital care.* A hospital may charge a beneficiary for services excluded from coverage on the basis of § 405.310(g) of this chapter (custodial care) or § 405.310(k) of this chapter (medically unnecessary services) and furnished by the hospital after all of the following conditions have been met:

* * * * *

(2) The attending physician agrees with the hospital's determination in writing (for example, by issuing a written discharge order). If the hospital believes that the beneficiary does not require inpatient hospital care but is unable to obtain the agreement of the physician, it may request an immediate review of the case by the PRO. Concurrence by the PRO in the hospital's determination will serve in lieu of the physician's agreement.

(3) The hospital (acting directly or through its utilization review committee) notifies the beneficiary (or person acting on his or her behalf) in writing that—

* * * * *

(iv) The determination of the PRO made after the beneficiary received the purportedly noncovered services will be appealable by the hospital, the attending physician, or the beneficiary under the appeals procedures that apply to PRO determinations affecting Medicare part A payment; and

* * * * *

(d) *Medically unnecessary diagnostic and therapeutic services.* A hospital may charge a beneficiary for diagnostic procedures and studies, and therapeutic procedures and courses of treatment (for example, experimental procedures) that are excluded from coverage under § 405.310(k) of this chapter (medically unnecessary items and services), even though the beneficiary requires continued inpatient hospital care, if those services are furnished after the beneficiary (or the person acting on his or her behalf) has acknowledged in writing that the hospital (acting directly or through its utilization review committee and with the concurrence of the intermediary) has informed him or her as follows:

* * * * *

(3) If the beneficiary receives the services, a formal determination on the validity of the hospital's finding is made by the intermediary and, to the extent that the decision requires the exercise of medical judgment, the PRO.

(4) The determination is appealable by the hospital, the attending physician, or the beneficiary under the appeals procedure that applies to determinations affecting Medicare Part A payment.

* * * * *

3. In § 412.44, the introductory language is revised to read as follows:

**§ 412.44 Medical review requirements: Admissions and quality review.**

Beginning on November 15, 1984, a hospital must have an agreement with a PRO to have the PRO review, on an ongoing basis, the following:

* * * * *

**§ 412.45 [Removed]**

4. Section 412.45 is removed.

5. Section 412.48(b) is revised to read as follows:

**§ 412.48 Denial of payment as a result of admissions and quality review.**

* * * * *

(b) When payment with respect to admission of an individual patient is denied by a PRO under paragraph (a)(1) of this section, and liability is not waived in accordance with §§ 405.330 through 405.332 of this chapter, notice and appeals are provided under procedures established by HCFA to implement the provisions of section 1155 of the Act. Right to Hearing and Judicial Review.

* * * * *

F. Subpart F is amended as follows:

## Subpart F—Payment for Outlier Cases

1. In § 412.82, the introductory language of paragraph (b) is revised to read as follows:

**§ 412.82 Payment for extended length of stay cases (day outliers).**

* * * * *

(b) The PRO must review and approve to the extent required by HCFA—

* * * * *

2. Section 412.84 is amended by revising paragraph (b); redesignating current paragraphs (c), (d), (e), and (f) as paragraphs (f), (g), (h), and (i) respectively; adding new paragraphs (c), (d), and (e); revising the introductory language of newly redesignated paragraph (f); and revising newly redesignated paragraph (i) as follows:

**§ 412.84 Payment for extraordinarily high cost cases (cost outliers).**

* * * * *

(b) The hospital must request additional payment—

(1) With initial submission of the bill; or

(2) Within 60 days of receipt of the intermediary's initial determination.

(c) Except as specified in paragraph (e) of this section, an additional payment for a cost outlier case is made prior to medical review.

(d) As described in paragraph (f) of this section, the PRO reviews a sample of cost outlier cases after payment. The charges for any services identified as noncovered through this review will be denied and any outlier payment made for these services will be recovered, as appropriate, after a determination as to the provider's liability has been made.

(e) If the PRO finds a pattern of inappropriate utilization by a hospital, all cost outlier cases from that hospital are subject to medical review, and this review may be conducted prior to payment until the PRO determines that appropriate corrective actions have been taken.

(f) The PRO reviews the cost outlier cases, using the medical records and itemized charges, to verify the following:

* * * * *

(i) The additional payment amount will be derived by first taking 60 percent of the difference between the hospital's adjusted cost for the discharge (as determined under paragraph (g) of this section) and the threshold criteria established under § 412.80(a)(2). The resulting amount will then be multiplied by the applicable Federal portion of the blend as indicated in § 412.82(c).

G. In Subpart G § 412.96 is amended by revising the title of paragraph (b), the title and the introductory language of paragraph (c), paragraphs (c)(1), (c)(2), and (f), and adding a new paragraph (g) to read as follows:

## Subpart G—Special Treatment of Certain Facilities

**§ 412.96 Special treatment: Referral centers.**

* * * * *

(b) *Criteria for cost reporting periods beginning on or after October 1, 1983.*

* * * * *

(c) *Alternative criteria for cost reporting periods beginning on or after October 1, 1985.* For cost reporting periods beginning on or after October 1, 1985, a hospital that does not meet the criteria of paragraph (b) of this section is classified as a referral center if it is located in a rural area (as defined in § 412.62(f)) and meets the criteria specified in paragraphs (c)(1) and (c)(2) of this section and at least one of the three criteria specified in paragraphs (c)(3), (c)(4), and (c)(5) of this section.

(1) *Case-mix index.* The hospital's case-mix index for the Federal fiscal year that ended prior to the beginning of the cost reporting period for which the hospital is seeking referral center status must be at least equal to the national or median urban regional case-mix index value set forth in each year's annual notice of prospective payment rates published under § 412.8(b). The methodology HCFA uses to calculate these criteria is described in paragraph (g) of this section.

(2) *Number of discharges.* For the hospital's most recently completed cost reporting period, its number of discharges (excluding discharges from subprovider and newborn units) is at least equal to the number of discharges under one of the two criteria set forth in each year's annual notice of prospective payment rates published under § 412.8(b).

* * * * *

(f) *HCFA review of referral center status.* The status of each hospital that is receiving a referral center adjustment will be reviewed by the HCFA regional office every three years to determine if the hospital continues to meet the criteria set forth in paragraphs (b) or (c)

of this section. If the determination is to the effect that the hospital no longer qualifies for a referral center adjustment, HCFA will discontinue the adjustment beginning on the first day of the hospital's next cost reporting period.

(g) *Methodology for calculating case-mix index criteria.* HCFA calculates the national and regional case-mix index value criteria as described in paragraph (g)(1) through (g)(5) of this section.

(1) *National criterion.* HCFA calculates a national case-mix index value for all hospitals subject to the prospective payment system and compares it to the 1981 national average case-mix index value of 1.00. The percentage of change between those two figures is used to update the 1981 national case-mix index criterion of 1.03.

(2) *Regional criterion.* HCFA calculates the median urban case-mix index values for each census region by updating the 1981 regional criterion using the percentage of change that is calculated under paragraph (g)(1) of this section.

(3) *Source of data.* In making the calculations described in paragraphs (g)(1) and (g)(2) of this section, HCFA uses all inpatient hospital bills received for discharges through the midpoint of the Federal fiscal year before the year in which the criteria will be effective.

(4) *Effective date.* HCFA sets forth the national and regional criteria in the annual notice of prospective payment rates published under § 412.8(b). These criteria are used to determine if a hospital qualifies for referral center status for cost reporting periods beginning on or after October 1 of the Federal fiscal year to which the notice applies.

(5) *Applicability of criteria to HCFA review of referral center status.* For purposes of the triennial HCFA review of a referral center's status as described in paragraph (f) of this section, the referral center's case-mix index value for Federal fiscal year is evaluated using the updated case-mix value criteria published in the subsequent Federal fiscal year's notice of prospective payment rates.

H. In Subpart H, § 412.118, the introductory language of the section is revised; the introductory language of paragraph (a) is reprinted for the convenience of the reader; paragraph (a)(1) is revised; current paragraphs (b) through (e) are redesignated as paragraphs (c) through (f) respectively; a new paragraph (b) is added; the introductory language of newly redesignated paragraphs (d) and (e) is reprinted for the convenience of the reader; newly redesignated paragraphs (d)(3), (e)(2), (e)(3), (e)(4), and (f) are revised; and a new paragraph (g) is added to read as follows:

## Subpart H—Payments to Hospitals under the Prospective Payment System

### § 412.118 Determination of indirect medical education costs.

For cost reporting periods beginning on or after October 1, 1984, to determine the indirect medical education costs, HCFA uses the following procedures:

(a) *Basic data.* HCFA determines for each hospital its—

(1) Ratio of full-time equivalent interns and residents to number of beds (as determined in paragraph (b) of this section), excluding those interns and residents in anesthesiology who are employed to replace anesthetists; and

* * * * *

(b) *Determination of number of beds.* For purposes of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period, not including beds assigned to newborns, custodial care, and excluded distinct part hospital units, and dividing that number by the number of days in the cost reporting period.

* * * * *

(d) *Determination of payment amount.* Each hospital's indirect medical education payment will be determined by multiplying the following three factors:

* * * * *

(3) The education adjustment factor determined under paragraph (c) of this section.

(e) *Count of interns and residents.* In order to have interns and residents included in the count under paragraph (a)(1) of this section, the following requirements must be met:

* * * * *

(2) The hospital must submit an annual report to its fiscal intermediary. The report must include the following information:

(i) A listing, by specialty, of all interns and residents assigned to the hospital and providing services to the hospital on September 1 of that year. If September 1 falls on a weekend or a Federal holiday, the next business day is used for purposes of the count of interns and residents. For cost reporting periods beginning on or after October 1, 1984 and before July 1, 1985, the hospital must also report this information for April 15, 1985.

(ii) The social security number of each intern and resident.

(iii) The hospital unit or department to which each intern and resident is assigned on the day of the count.

(3) No intern or resident will be counted as more than one full-time employee on the date counted, regardless of the number of hospitals in which he or she is providing services.

(4) Fiscal intermediaries must verify the correct count of interns and residents and may review the hospital's entire cost reporting period.

(f) *Limits on count of interns and residents.* (1) Interns and residents who are assigned to a freestanding family practice center or an excluded distinct part hospital unit on the day that the count of interns and residents (as described in paragraph (e)(2)(i)) is made are not counted as full-time equivalents. Only the percentage of time that these interns and residents spend in the portion of the hospital subject to the prospective payment system on the day the count is made is used to determine the indirect medical education adjustment.

(2) For cost reporting periods beginning on or after October 1, 1985, interns and residents who are assigned to the outpatient department of the hospital on the day the count is made are subject to the provisions of paragraph (f)(1) of this section.

(3) For cost reporting periods beginning on or after October 1, 1985, the number of interns and residents assigned to ancillary departments of the hospital will be apportioned between inpatient and outpatient settings based on the ratio of each ancillary department's inpatient and outpatient charges to total department charges, respectively. In determining the indirect medical education adjustment, only that percentage attributable to furnishing inpatient services will be included in the computation of the intern and resident-to-bed ratio.

(g) *Intermediary review.* Based on its review of a hospital's documentation concerning the hospital's count of interns and residents under this section, the intermediary may adjust the intern and resident-to-bed ratio for purposes of the final indirect medical education payment.

(Catalog of Federal Domestic Assistance Programs No. 13.773, Medicare—Hospital Insurance)

Dated: August 2, 1985.

**Carolyne K. Davis,**

*Administrator, Health Care Financing Administration.*

Approved: August 27, 1985.

**Margaret M. Heckler,**

*Secretary.*

**Editorial Note:** The following addendum and appendix will not appear in the Code of Federal Regulations.

## ADDENDUM—SCHEDULE OF STANDARDIZED AMOUNTS EFFECTIVE WITH DISCHARGES ON OR AFTER OCTOBER 1, 1985, AND UPDATE FACTORS AND TARGET RATE PERCENTAGES EFFECTIVE WITH COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 1985

### I. Summary and Background

In this addendum to the final rule we are making changes in the methods, amounts, and factors for determining prospective payment rates for Medicare inpatient hospital services during the third and final year of the transition period of the prospective payment system. In addition, the addendum sets forth new target rate percentages for determining the rate-of-increase limits (target amounts) for hospitals excluded from the prospective payment system.

Under the prospective payment system, for hospital cost reporting periods beginning October 1, 1985 through September 30, 1986, except for sole community hospitals, each hospital's payment per discharge will be the sum of a Federal portion that is 75 percent of the Federal rate and a hospital-specific portion that is 25 percent of the hospital-specific rate (section 1886(d)(1)(C) of the Social Security Act (the Act)). Sole community hospitals will continue to be paid on the basis of a rate per discharge composed of 75 percent of the hospital-specific rate and 25 percent of the applicable Federal regional rate. We note that, while the changes to the hospital-specific portion of the prospective payment rate are determined on the basis of cost reporting periods, the changes to the Federal portion are determined on the basis of the Federal fiscal year (FY).

During FY 1986, the Federal rates will be comprised of a blend of 50 percent of the national rate and 50 percent of the appropriate regional rate, as required by section 1886(d)(1)(D) of the Act. During the first year of the transition period (that is, FY 1984), the Federal rates were comprised solely of the regional rate. During the second year, FY 1985, the Federal rates are comprised of a blend of 25 percent of the national rate and 75 percent of the regional rate.

As discussed in section II below, we are making changes (proposed on June 10, 1985, 50 FR 24366) in the determination of the prospective payment rates. The method for determining these rates was published in an interim final rule on September 1, 1983 (48 FR 39752) and modified in final rules published on January 3, 1984 (49 FR 234) and August 31, 1984 (49 FR 34723). The changes, to be applied prospectively, affect the calculation of both the Federal rates (adjusted standardized amounts) and the hospital-specific rates that are used to determine transition period prospective payment rates. As part of these changes, we are incorporating adjustments for the updated market basket index and additional adjustments as authorized under section 1886(e)(4) of the Act.

We are also including in the discussion below a summary of the comments we received on the addendum of the June 10, 1985 notice of proposed rulemaking (NPRM or proposed rule) and our responses to the comments.

Section III, below, sets forth our changes in determining the rate-of-increase limits for hospitals excluded from the prospective payment system. Section IV contains the tables referred to throughout the preamble to the final rule and in this addendum.

### II. Changes To Prospective Payment Rates and DRG Weighting Factors for FY 1986

The basic methodology for determining Federal regional and national prospective payment rates is set forth at § 412.63, and for hospital-specific rates is set forth in § 412.73. Below, we discuss the manner in which we are making changes to some of the factors and methodology used for determining the prospective payment rates. The Federal rate changes, the revised wage index, and the DRG weights will be effective with discharges occurring on or after October 1, 1985. Updated hospital-specific rates will be effective for hospital cost reporting periods beginning on or after October 1, 1985.

In summary, we are establishing the FY 1986 Federal rates (that is, the standardized amounts set forth in Table 1, below) by:

- Restandardizing the base year cost data to reflect adoption of the survey-based gross wage index (described in section II.A.1.);
- Grouping the standardized amounts by urban/rural averages for the nine census regions and the nation, reflecting the most recent geographic designations (described in section II.A.2.);
- Updating the standardized amounts by zero percent, after considering—
  - —Certain factors that resulted in payment rates for FY 1985 that were overstated by 7.5 percent;
  - —The forecasted FY 1986 market basket increase of +4.27 percent; and
  - —A policy target adjustment factor of −1.5 percent (described in section II.A.3.);
  - —The adjustment factor (+.31 percent) for Part B costs and FICA taxes (described in section II.A.4.); and
- Applying the same adjustment factors for nonphysician anesthetist costs and outlier payments as were used for FY 1985 (described in section II.A.4.).

Further, for cost reporting periods beginning in FY 1986, we are not increasing either the hospital-specific rates for hospitals under the prospective payment system, or the rate-of-increase limits for hospitals excluded from the prospective payment system.

Although we believe the standardized amounts for FY 1985 were so overstated that a significant reduction could be justified, we are not reducing them for FY 1986. Rather, we are maintaining them at the same level as the FY 1985 payment rates. Thus, the amounts in Table 1 differ from the FY 1985 standardized amounts only as a result of restandardization to reflect the new wage index, as well as changes in MSA area designations announced by EOMB since September 30, 1984. In section II.A.3. below, we discuss our reasons for maintaining the FY 1986 Federal rates at the FY 1985 level.

The new DRG weights and outlier criteria are included in Table 5 of section IV, below.

*Comment*: Several commenters requested that special adjustments be made to the average standardized amounts for the costs of uncompensated care, labor room days, and malpractice insurance.

*Response*: Section 1886(d) of the Act requires that the prospective payment rates serve as total Medicare payment for inpatient operating costs of each discharge for all items and services furnished other than physicians' services. Operating costs are defined as all routine operating costs, ancillary service operating costs, and special care unit costs. Uncompensated care represents a loss of revenue and is not an operating cost. However, the operating costs associated with uncompensated care, labor room days, and malpractice insurance that are attributable to services furnished to Medicare patients, are already a part of inpatient operating costs and an

appropriate payment is already made for these costs under the prospective payment system.

*A. Calculation of Adjusted Standardized Amounts*

1. Standardization and Restandardization of Base Year Costs Per Case Used in Calculation of Federal Rates

Section 1886(d)(2)(A) of the Act requires the establishment of base year cost data containing allowable operating costs per discharge of inpatient hospital services for each hospital. The preamble to the interim final rule, published September 1, 1983 (48 FR 39763), contains a detailed explanation of how base year cost data are established and how they are used in computing the Federal rates.

Section 1886(d)(2)(C) of the Act requires that the updated base year per discharge costs be standardized in order to remove from the cost data the effects of certain causes of variation in cost among hospitals. These include case-mix, wage levels, cost of living, and indirect medical education costs. We have decided to restandardize the base year costs to reflect the survey-based wage index.

As stated in the proposed rule (50 FR 24390), we do not believe that section 1886(d) of the Act contemplates rebasing the standardized amounts. Rather, it directs that the rates be updated annually. However, there has been much discussion concerning the desirability of rebasing the standardized amounts so that they are more reflective of hospital behavior under the prospective payment system. There has been concern that changes in hospital behavior, such as shorter lengths of stay and shifts of services to the outpatient setting, are difficult to quantify as part of the annual update because of the limited amount of data available to estimate the effects of these factors. Since rebasing the standardized amounts would automatically reflect changes in hospital behavior under the prospective payment system, it may be appropriate to consider such rebasing in the future.

a. *Adjustments for Variation in Hospital Wage Levels.* Section 1886(d)(2)(C)(ii) of the Act requires that the updated amounts be standardized by adjusting for variations among hospitals in the average area hospital wage level. Therefore, the updated average cost per discharge is divided into labor-related and nonlabor-related portions. We established labor and nonlabor portions, based on the labor and nonlabor components of the hospital market basket, and standardized the labor portion of the FY 1984 and FY 1985 standardized amounts using the Bureau of Labor Statistics' (BLS) area wage index. However, adoption of a new wage index (discussed in section III of the preamble of this final rule) requires us to restandardize the base year costs used to calculate the standardized amounts. Therefore, we have removed the effect of the previous standardization for each hospital's BLS wage index by multiplying each hospital's average cost per discharge value by the old index and by restandardizing the amounts by dividing that result by the survey-based gross wage index.

The comments and responses on the adoption of a new wage index are located in section III of the preamble to this final rule.

b. *Variations in Case Mix Among Hospitals.* Section 1886(d)(2)(C)(iii) of the Act requires that the updated amounts be standardized to adjust for variations in case mix among hospitals. The methodology used for determining the appropriate adjustment factor (that is, the case-mix index) is explained in the September 1, 1983 interim final rule (48 FR 39768–39771). A case-mix index has been calculated for each hospital based on 1981 cost and billing data.

Standardization, necessary to neutralize inpatient operating costs for the effects of variations in case mix, is accomplished by dividing the hospital's average cost per Medicare discharge by that hospital's case-mix index. Table 3a, section VII of the addendum to the September 1, 1983 interim final rule (48 FR 39847–39870), contains the case-mix index values used for this purpose for the FYs 1984 and 1985 rates.

Because we are using new charge-based DRG weights for discharges occurring in FY 1986, we considered calculating new case-mix indexes based on 1981 charge data, and using these indexes to restandardize the base year costs used to determine the prospective payment rates. This would be technically the most accurate method for restandardizing the 1981 cost data. However, we found that restandardizing with 1981 charge-based case-mix index values would have a negligible effect on the standardized amounts. Therefore, we are continuing to standardize for case mix using 1981 cost data, and we have decided not to restandardize with 1981 charge-based data.

*Comment:* One commenter suggested that we consider restandardizing the Federal payment rates using 1981 charge-based (rather than cost-based) case-mix indexes. Because the charge data are slightly less compressed than the cost data, the commenter argued that failure to restandardize could have the potential outcome of paying hospitals with high case-mix indexes too much and hospitals with low case-mix indexes too little.

*Response:* We recognized this point in the NPRM (50 FR 24391), but argued that the differences in the Federal payment rates are small and the resulting payment differences are negligible. We would like to note further that there are technical disadvantages to restandardizing the rates for the use of charge-based relative weights. In particular, the charge-based case-mix indexes would incorporate all the limitations of the MEDPAR data that are inherent in the cost-based case-mix indexes currently used in the standardization. In addition, the charge-based case-mix indexes that we have calculated are based on only the 358 DRGs for which the 1981 MEDPAR data contain enough cases to calculate a reliable relative weight. We do not have charge-based weights for the original set of 109 low volume DRGs. Finally, restandardization of the rates with charge-based case-mix indexes may reduce total payments because hospitals with high case-mix indexes account for a disproportionately large percentage of total Medicare cases.

c. *Indirect Medical Education Costs.*—Section 1886(d)(2)(C)(i) of the Act requires that the updated amounts be standardized for indirect medical education costs. Therefore, in establishing the standardized amounts used to determine the FY 1984 and FY 1985 prospective payment rates, after adjusting each hospital's inpatient operating cost per discharge for inflation and case-mix, we divided each cost by 1.0 plus the product of double the education adjustment factor (5.795 percent, which, when doubled, yields 11.59 percent) and the individual hospital's adjusted intern and resident-to-bed ratio. We determined that adjusted ratio by dividing the hospital's number of full-time equivalent interns and residents for the cost reporting period by the hospital's bed size determined at the beginning of the data base period to obtain the hospital's intern and resident-to-bed ratio, and dividing that ratio by 0.1.

We are not revising the education factor, because we do not have the latest intern and resident counts needed to rerun the regression. Therefore, we cannot restandardize the updated amounts to reflect the latest intern and resident-to-bed ratios. In addition, we do not believe that the indirect medical education factor would necessarily

change even if the data were available. That factor is based on considering interns and residents that work 35 or more hours per week as full-time, and those that work less than 35 hours as half-time. Even if certain interns and residents worked some hours furnishing services to out outpatients, they probably would have still spent 35 or more hours furnishing services to inpatients. Therefore, since the count of interns and residents in 1981 almost certainly would not have changed significantly had outpatient time been eliminated, the indirect medical education factor is unlikely to have changed. We will, however, reestimate the relationship between costs and teaching activity in the future once data become available.

The comments and responses on the calculation of indirect medical education costs are located in section IV.F. of the preamble to this final rule.

d. *Cost-of-Living Factor for Alaska and Hawaii.* Section 1886(d)(5)(C)(iv) of the Act authorizes the Secretary to provide for such adjustments to the payment amounts as the Secretary deems appropriate to take into account the unique circumstances of hospitals located in Alaska and Hawaii.

Generally, these two States have higher levels of cost in comparison to other States in the nation. The higher cost of labor is accounted for in the wage index adjustments discussed above. However, the higher cost-of-living in these States also affects the cost of nonlabor items (for example, supplies and equipment). Therefore, in order to remove the effects of the higher nonlabor costs from the overall cost data (that is, for standardization purposes), the nonlabor portion of the average cost per Medicare discharge in hospitals located in Alaska and Hawaii is divided by an appropriate cost-of-living adjustment factor. The factors used for this adjustment have not changed from FY 1985; therefore, we are not restandardizing the base-year cost data for cost-of-living adjustments. We note that some of the adjustment factors were incorrect in the NPRM. The table below presents the most recent (FY 1985) cost-of-living adjustment factors.

We received no comments on this issue.

**Table of Cost-of-Living Adjustment Factors, Alaska and Hawaii Hospitals**

| | |
|---|---|
| Alaska—All areas | 1.25 |
| Hawaii: | |
| Oahu | 1.225 |
| Kauai | 1.15 |
| Maui | 1.20 |
| Molokai | 1.20 |
| Lanai | 1.20 |
| Hawaii | 1.125 |

(The above factors are based on data obtained from the U.S. Office of Personnel Management, published in their FPM-591 letter series.)

2. Grouping of Urban/Rural Averages Within Geographic Areas

Under section 1886(d)(2)(D) of the Act, the average standardized amounts per discharge must be determined for hospitals located in urban and rural areas of the nine census divisions and the nation.

For FY 1986 the Federal rates will be comprised of 50 percent of the national rate and 50 percent of the regional rate (section 1886(d)(1)(D) of the Act). Therefore, Table 1 contains 20 standardized amounts (ten urban amounts and ten rural amounts further divided into labor-related and nonlabor-related portions). The methodology for computing the national average standardized amounts is identical to the methodology for determining the regional amounts, except that the national urban and rural groups include hospitals from all urban or rural geographic areas, respectively.

On June 27, 1985, EOMB announced, effective June 30, 1985, revised listings of the Metropolitan Statistical Area (MSA) designations that are used in calculating the standardized amounts. We note that under the law *Making Continuing Appropriations for FY 1985,* (Title I of Pub. L. 98–473), enacted October 12, 1984, the designation of the St. Louis MSA was also changed. As stated in the January 3, 1984 final rule (49 FR 253), such changes in designation will not be recognized in the prospective payment rates until the beginning of each new Federal fiscal year following the announced changes. The revised wage index (as well as the standardized amounts) included in this final rule incorporates this change, as well as those effective June 30, 1985, which will be effective October 1, 1985 for prospective payment purposes. Note that such changes in the MSA designations account for modest changes in the nonlabor portions, as well as the labor portions, of the standardized amounts.

3. Updating the Average Standardized Amounts

a. *Legal Requirements.* In accordance with section 1886(d)(3)(A) of the Act, we are adjusting the urban and rural average standardized amounts using the applicable percentage as determined by the Secretary in accordance with section 1886(e)(4) of the Act. That section reads as follows:

(4) Taking into consideration the recommendations of the Commission [that is, the Prospective Payment Assessment Commission, or ProPAC], the Secretary shall determine for each fiscal year (beginning with fiscal year 1986) the percentage change which will apply for purposes of this section as the applicable percentage increase (otherwise described in subsection (b)(3)(B)) for discharges in that fiscal year, and which will take into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality.

As prescribed by section 1886(e)(2) of the Act, the Commission, in making its recommendations to the Secretary:

shall take into account changes in the hospital market-basket described in subsection (b)(3)(B), hospital productivity, technological and scientific advances, the quality of health care provided in hospitals (including the quality and skill level of professional nursing required to maintain quality care), and long-term cost-effectiveness in the provision of inpatient hospital services.

Section 1886(b) of the Act sets forth the requirements under which a rate of increase limit is established for the inpatient operating costs of hospitals excluded from the prospective payment system. Under this section, a target amount is determined annually for each hospital cost reporting period, based on each hospital's base year cost per case, updated by an "applicable percentage increase."

This "applicable percentage increase" is defined in section 1886(b)(3)(B) as:

one-quarter of 1 percentage point plus the percentage, estimated by the Secretary before the beginning of the period or year, by which the cost of the mix of goods and services (including personnel costs but excluding non-operating costs) comprising routine, ancillary, and special care unit inpatient hospital services, based on an index of appropriately weighted indicators of changes in wages and prices which are representative of the mix of goods and services included in such inpatient hospital services, for such cost reporting period or fiscal year will exceed the cost of such mix of goods and services for the preceding 12-month cost reporting period or fiscal year.

We have used the hospital market basket index as the measure of the cost of goods and services for determining both prospective payment rates and the target amounts applicable to hospitals and units excluded from the prospective payment system. For FY 1986 and subsequent fiscal years, section 1886(e)(4) of the Act requires that the

determination of a percentage change, considering at least the factors set forth in that section and section 1886(e)(2) of the Act, *will substitute for* the "applicable percentage increase" that would otherwise apply as it did in FY 1984 and FY 1985. However, section 1886(b)(3)(B) of the Act specifies that for FY 1986, the percentage determined under section 1886(e)(4) may not exceed the applicable percentage increase that would otherwise be determined for that period. (Note that, under the statute, from FY 1986 on, the percentage determined by the Secretary under section 1886(e)(4) will be applied to *both* the prospective payment rates and the rate-of-increase limits applicable to hospitals and units excluded from the prospective payment system. Although the statute is not explicit on using the same percentage, we believe that the update factor is to be the same for both classes of hospitals. Section 1886(e)(2) of the Act requires ProPAC to make recommendations on the "appropriate percentage change [singular] which should be affected for hospital inpatient discharges under subsections (b) [non-prospective payment system hospitals] and (d) [prospective payment system hospitals] . . . ." Similarly, section 1886(e)(3) of the Act refers to "an" appropriate change factor and section 1886(e)(4) of the Act to "the percentage change.")

*Comment:* Many commenters stated that we are overstepping our authority by providing for a zero percent increase in the FY 1986 prospective payment rates from the FY 1985 levels. They stated that we have circumvented the legislative prerogatives of Congress by administratively setting Medicare prospective payments for FY 1986 at the FY 1985 levels in order to reduce the Federal budget deficit, and that we do not have the authority to make those budget decisions.

*Response:* We believe that our proposal to hold the FY 1986 prospective payment rates at FY 1985 levels is not only analytically defensible and supportable, but also fully complies with statutory requirements. Our decision not to inflate the FY 1986 prospective payment rates was made with explicit regard to the law.

Sections 1886(e) (2) and (4) of the Act specify the factors that ProPAC and the Secretary must consider in making an appropriate update determination. These factors include, but are not limited to, the following:

- Changes in the cost of goods and services that hospitals purchase (that is, market basket inflation or deflation).
- Hospital productivity.
- Technological and scientific advances.
- Quality of health care provided in hospitals.
- Long-term cost effectiveness in the provision of inpatient services.

Each of these factors, together with ProPAC's recommendations, was given careful consideration in the development of the proposed rule and this final rule as required under sections 1886(e) (2) and (4) of the Act.

In addition, section 1886(b)(3)(B) of the Act provides the Secretary authority to establish a rate of increase not to exceed the annual rate of increase in the hospital market basket plus one-quarter of one percentage point. While the law specifies the upper limit that could be used to establish the prospective payment rates, it neither requires that the ceiling rate be implemented nor prohibits the establishment of lower rates.

We considered the ramifications of not inflating the FY 1985 prospective payment rates. As explained below, we could have justified a reduction of 4.42 percent. We believe that sections 1886(e) (2) and (4) of the Act provide the Secretary sufficient authority to maintain FY 1986 prospective payment rates at the FY 1985 levels. According to section 1886(e)(4), the Secretary has the discretionary authority to determine the appropriate "percentage change" in the payment rates beginning with FY 1986. As part of this authority, the Department is responsible for ensuring that the Medicare Trust Funds are not overpaying for services provided to Medicare beneficiaries. Therefore, as further justified below, a zero percent increase in the prospective payment rates for FY 1986 is appropriate.

*Comment:* A number of commenters stated that nothing in the statute authorizes the Secretary to adjust the prior year's rates. They stated that the law authorizes the Secretary to "update previous standardized amounts," not to recalculate them.

*Response:* We believe that section 1886(d)(3)(A) of the Act gives the Secretary authority to consider the appropriateness of the prior year's standardized amounts as part of the update of the FY 1986 payment rates. This section states that the standardized amounts for fiscal years subsequent to FY 1985 are to be "adjusted in accordance with" the Secretary's final determination of the "percentage change" under section 1886(e)(4) of the Act. In addition, section 1886(d)(3)(A) of the Act specifically authorizes the Secretary to adjust the standardized amounts to reflect the latest case-mix data.

We believe that, in providing discretionary authority to adjust the standardized amounts, Congress intended that, rather than merely to update the rates mechanically, we should evaluate the appropriateness of the current payment levels. If we were to update the previous standardized amounts without consideration for how much they are overstated, as the commenters suggest, this would guarantee a windfall to hospitals that clearly Congress could not have intended as meeting the "amounts necessary for the efficient and effective delivery" of medically needed health care. In this connection, Congress also prescribed specific factors to be considered by ProPAC in making its recommendation on the "percentage change" for FY 1986 and beyond. In commenting on the proposed rule, ProPAC agreed that it was reasonable to consider the appropriateness of current payment levels in developing an update factor. While ProPAC may have disagreed with the extent of our adjustments to the prior years' rates, it supported the nature of these adjustments. A discussion of ProPAC's comments concerning the update factor is included elsewhere in this section.

*Comment:* A few commenters stated that we are required by law to increase the payment rates for FY 1986. They state that sections 1886(d)(3)(A) and 1886(e)(4) of the Act, which address the update of the previous years' standardized amounts, specifically refer to the "percentage increase" and, therefore, preclude us from not increasing the payment rates.

*Response:* We disagree with this interpretation. Section 1886(d)(3)(A) of the Act, in referring to the "percentage increase", is addressing the FY 1985 update and not subsequent updates. In addition, for FY 1986 and subsequent fiscal years, section 1886(e)(4) of the Act requires that the determination of a percentage change, considering at least the factors set forth in that section and section 1886(e)(2) of the Act, *will substitute for* the "applicable percentage increase" that would otherwise apply as it did in FY 1984 and FY 1985. We believe that this change in terminology clearly implies that a factor other than an increase may be applied for updates beginning with FY 1986.

b. *Factors Considered in Determining the Proposed FY 1986 Update.* Based on the legal requirements for establishing the FY 1986 update factor, we had to consider at least the following factors in addition to the hospital market basket index: hospital productivity, technological and scientific advances,

quality of care, cost-effectiveness, and case-mix data. In addition, we considered prior years' experience with the prospective payment system.

Since the standardized amounts for FY 1985 are used as the basis for the determination of rates for later years, the level of the FY 1985 standardized amounts must be corrected for any experience that developed since they were published. We believe that it is necessary, each year, to review the appropriateness of the level of the previous year's prospective payment rates for providing reasonable payment for inpatient hospital services furnished to beneficiaries. Further, we think this review must include assessment of whether the previous year's prospective payment rates have established adequate incentives for the efficient and effective delivery of needed care.

In addition to this general consideration, the FY 1985 adjusted average standardized amounts (Federal rates) were required by law to be adjusted to achieve budget neutrality; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be neither more nor less than we estimated would have been paid under prior legislation for the costs of the same services. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years.

Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were higher than necessary to achieve budget neutrality. Therefore, we have updated the FY 1985 standardized amounts using a factor that takes into account the overstatement of the FY 1985 amounts to ensure that accuracy of the FY 1986 standardized amounts. To this end, we have identified several factors, discussed in section II.A.3.c., below, that contributed to the overstatement of the FY 1985 standardized amounts. We have determined an appropriate percent value for each of them, and have combined them into a proposed composite correction factor for FY 1986 that equals −7.5 percent.

In addition, we have developed factors representing productivity, technological advances, and the elimination of ineffective practice patterns, which are necessary to ensure the cost-effective delivery of care. Each of these factors interacts with the others, to some extent, and has an impact on the quality of care. Making conservative assumptions, we have determined an appropriate percent value for each of these factors, taking into consideration their potential effect on quality. We have combined these values into a composite policy target adjustment factor, as discussed in section II.A.3.e., below. For FY 1986, this factor equals −1.5 percent.

The Secretary is required under section 1886(e)(4) of the Act to make those adjustments in establishing the update factor that are ". . . necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality." Establishing FY 1986 prospective payment rates based on FY 1985 rates that have been demonstrated to be overstated, clearly would not comport with the statutory requirement that the rates represent payment for efficiently delivered care.

Since the forecasted hospital market basket increase for FY 1986 is +4.27 percent, and the adjustment for Part B costs and FICA taxes is +.31 percent, it is clear that there is a potential justification of a −4.42 percent decrease in the FY 1986 standardized amounts as compared to those for FY 1985 as described below:

| | Percent |
|---|---|
| Forecasted market basket increase | +4.27 |
| Part B costs and FICA taxes | +.31 |
| Composite correction factor | −7.5 |
| Composite policy target adjustment factor | −1.5 |

However, for the reasons discussed in section II.A.3.f., below, we have decided that such a decrease is undesirable. Therefore, we are maintaining the FY 1986 standardized amounts at the same average level as FY 1985, in effect applying a zero percent update factor.

*Comment:* Many commenters stated that our framework for determining the update factor is not justified and is contrary to the recommendations of ProPAC. Other commenters stated that we had completely ignored ProPAC's recommendations.

*Response:* We disagree with these commenters. Our framework for developing an update factor is very similar to ProPAC's. For example, ProPAC recommended similar adjustments for case-mix increases and market basket forecast errors. While the extent of these adjustments and our methodology for making them may have differed somewhat from those recommended by ProPAC, the nature of the adjustments is very similar. In fact, in commenting on the proposed rule and notice of rates, ProPAC stated its belief that we had constructively considered its recommendations. Along with its comments, ProPAC submitted the following table comparing the components of our updating factor for the FY 1986 rates with its recommendations. We have added a third column to reflect our most recent information. We believe this table demonstrates that, in principle, our framework for updating the FY 1986 rates is very similar to ProPAC's.

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ESTIMATED INCREASE IN PROSPECTIVE PAYMENT AMOUNTS FOR FY 1986: COMPARISON OF NPRM TO PROPAC RECOMMENDATION (percentage change)

| | NPRM | ProPAC | Final Rule |
|---|---|---|---|
| FY 1986 market basket increase | 4.85 | 4.85 | 4.27 |
| Previous market basket forecast errors | -1.30 | -0.57[a] | -1.20 |
| Policy Target Adjustment Factor or Discretionary Adjustment Factor | -1.50 | -1.00 | -1.50 |
| Components: | | | |
| Productivity | -1.0 | -1.5 to -2.0 | -1.0 |
| Cost-effective technologies | 1.5 | 1.5 to 2.0 | 1.5 |
| Product change | | -1.0 | |
| Cost-ineffective practice patterns | -2.0 | | -2.0 |
| SUBTOTAL (market basket plus adjustment factor) | 2.05 | 3.28 | 1.57 |
| Observed change in case mix | -4.90 (1981-1985) | -2.00[b] (1985 only) | -6.30 (1981-1985) |
| Part B costs and FICA taxes | 0 | 0 | .31 |
| Case-mix changes within DRGs during FY 1985 | 0 | 0.80[c] | 0 |
| TOTAL | -2.85 | 2.08 | -4.42 |
| PROPOSED INCREASE | 0 | 2.08 | 0 |

[a] The Commission recommended that errors in forecasting internal price proxies (the wage component of the market basket) should not be corrected. The estimate of -0.57% (44% of -1.3%) assumes that the magnitude of the forecast errors was about the same for wages as for other price change measures.

[b] ProPAC estimate based on the findings of the Rand study cited in the proposed rule. The 2% increase in observed case mix for fiscal year 1985 is based on RAND's estimate of a 0.5% quarterly increase in case mix after hospitals have switched to the prospective payment system.

[c] The 0.8% increase estimated here for fiscal year 1985 takes into account historical trends in real case-mix change, recent shifts to outpatient treatment, and within-DRG case-mix changes that would not show up in the case-mix index.

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The extent of the case-mix adjustment continues to be the most significant area of difference. ProPAC believes we should adjust only for case-mix increases occurring in FY 1985. As explained in the NPRM (50 FR 24393), we believe the adjustment should also reflect previously unaccounted for changes in case mix prior to FY 1985. Otherwise, the standardized amounts, which serve as the basis for determining future prospective payment rates, would be overstated. The basis for ProPAC's recommendation is unclear since failure to also adjust for case-mix increases prior to FY 1985 would result in perpetuating overstated standardized amounts. In order to ensure an appropriate payment base for updating future rates, we believe it is essential to adjust for the entire overstated amount.

ProPAC's comments on other components of the update factor, such as adjusting for real case-mix increases, are discussed along with other comments received on these issues.

*Comment:* Several commenters maintained that our proposed 4.9 percent reduction in the FY 1986 standardized payment rates to correct for the understatement in the FY 1984 and FY 1985 budget neutrality adjustments attributable to case-mix increases beyond those recognized in the 1981 MEDPAR file was in violation of section 1886(e)(1) of the Act. These commenters pointed out that the budget neutrality provisions in section 1886(e)(1) only apply to the determination of the FY 1984 and FY 1985 prospective payment rates. None of the factors set forth in the law explicitly provide for computing the FY 1986 standardized amounts to include budget neutrality. Therefore, these commenters claimed that applying the proposed 4.9 percent reduction to correct the amount of the budget neutrality offsets for FY 1984 and FY 1985 due to an underestimation of the rate of increase in case mix is inappropriate. The commenters argued that the FY 1986 prospective payment rates should be calculated based on the FY 1984 and FY 1985 standardized amounts *prior* to the adjustment of these amounts for budget neutrality.

*Response:* Section 1886(e)(1) of the Act requires that the prospective payment system result in aggregate program reimbursement equal to "what would have been payable" under the limits enacted under the Tax Equity and Fiscal Responsibility Act of 1982 (Pub. L. 97-248) during FYs 1984 and 1985. That is, for FY 1984 and FY 1985, the prospective payment system should be "budget neutral." Section 1886(e)(1)(A) states in part, "The Secretary shall provide for such proportional adjustment . . . as may be necessary to assure that—

(i) The aggregate payment amounts otherwise provided . . . for that fiscal year . . . are not greater or less than—

(ii) The target percentage . . . of the payment amounts which would have been payable . . . for that fiscal year . . . under the law as in effect before the date of enactment of the Social Security Amendments of 1983."

In order that total estimated payments under the prospective payment system would equal "what would have been payable" under prior law, we applied an adjustment factor to both the Federal and hospital-specific portion of each hospital's blended prospective payment rate at the time the rate was determined. The budget neutrality adjustments for both FY 1984 and FY 1985 were both offsets, although an add-on could have been required to ensure compliance with law. Our preliminary determination of the case-mix adjustment for FY 1984 was 3.38 percent. We used an additional 1.05 percent for the FY 1985 rates. The portions of the budget neutrality offsets for these Federal fiscal years solely attributable to the estimated rate of increase in case mix were 3.38 percent and 1.05 percent, respectively.

The commenter's position is that a literal reading of the law precludes *any* reconsideration of the budget neutrality adjustment factors incorporated in the FY 1984 and FY 1985 standardized amounts in establishing payment rates for FY 1986. We disagree. The estimate of the rate of change in case mix affects the accuracy of the initially computed budget neutrality adjustments. Since our latest measure is more accurate than the earlier measurements used to compute the previously published factors because of the availability of more complete and later data, its use should result in a more precise approximation of the amounts that should have been paid in FY 1984 and FY 1985, if we had been able to achieve budget neutrality accurately. There is no reason to believe that Congress would have intended that the hospital industry receive a windfall as a result of these misestimations. Because the creation of overpayments and underpayments for FY 1984 and FY 1985 through retroactive implementation of revised budget neutrality adjustments would not comport with the basic principle of prospectivity of the prospective payment system, we have not applied these adjustments retroactively, but have converted these factors prospectively by adjusting the FY 1986 rates accordingly.

We have also considered the commenter's position that FY 1984 and FY 1985 standardized rates be recalculated to remove the entire effect of budget neutrality prior to developing the FY 1986 payment rates. We do not agree that the prior years' standardized rates before budget neutrality should serve as the basis for updating the FY 1986 rates. Since the budget-neutralized standardized amounts represent the actual payment rates used to pay hospitals in FY 1985, we believe the "percentage change" for FY 1986 should be applied to these amounts. In addition, section 1886(d)(3)(A) and (C) of the Act does not explicitly require that the update factor apply to the FY 1985 payment rates prior to the adjustments for budget neutrality in FY 1985.

However, absent the budget neutrality requirement applicable to FY 1984 and FY 1985 payment rates, we believe an adjustment to remove the effects of coding-related case-mix index increases from the standardized amounts would still be necessary. Since our analysis and RAND's study indicate that by far the greatest portion of the observed increase in case mix measures is due to coding changes, we would be overpaying on a prospective basis, because the case-mix increase would not reflect real changes in resource use, but only improve coding. These case-mix increases should not be reflected in the standardized amounts because they are unrelated to actual increases in costs per case. In addition, we believe the language in section 1886(d)(3)(A) of the Act requires that the standardized rates for fiscal years subsequent to FY 1985 be adjusted (that is, deflated) to reflect the most recent case-mix data available. Even if we were to accept the commenters' premise that the update factor should be applied to FY 1985 standardized amounts prior to budget neutrality, the result would be the same (that is, a zero percent update for FY 1986). The following table illustrates the adjustments that would apply to the FY 1986 update if the budget neutrality adjustment was eliminated. We recomputed the applicable overall rate of increase in the FY 1986 rates to remove the budget neutrality offset and case-mix rates of increase previously recognized in FY 1984 and FY 1985.

| | Percent |
|---|---|
| Forecasted market basket increase for FY 1986 | +4.27 |
| Change due to elimination of budget neutrality [1] | [2] +5.26<br>[3] +4.82 |

| | Percent |
|---|---|
| Change due to elimination of case-mix increases previously recognized in FY 1984 and FY 1985 [4] | +1.05 |
| Reduction in rates due to case-mix increase CY 1981–FY 1985 (as of June 1985) [5] | −8.19 |
| Change due to market basket forecasting error [6] | −1.5 |
| Policy target adjustment factor | −1.5 |
| Productivity | −1.0 |
| Cost effective technologies | +1.5 |
| Cost ineffective practice patterns | −2.0 |
| Total | [2] −0.61 |
| | [3] −1.05 |

The combined effect is still a reduction in the standardized amounts for FY 1986 compared to those for FY 1985

[1] 1.950 (Regional budget neutrality adjustment factor)=1.0528, 1.954 (National budget neutrality adjustment factor)=1.0492
[2] Regional.
[3] National.
[4] The 3.38 percent case-mix adjustment, and the .31 percent adjustment for Part B costs and FICA taxes, are included as part of the above budget neutrality adjustments.
[5] This factor represents the nominal increase in case mix from the 1981 MEDPAR file to FY 1985, and does not include any "real" case-mix increase. This figure was derived using the results of the RAND study, which found that 2.2 percentage points (or 26.2 percent) of the 8.4 percent observed case-mix increase for 1984 was related to "real" increases in case mix. Therefore, 73.8 percent (or 6.19 percentage points) of the 11.1 percent increase in average case-mix index through FY 1985 is nominal.
[6] This factor is the compounded difference between the latest FY 1984 and FY 1985 projections, and the FY 1984 and FY 1985 projections provided in the addendum to the August 31, 1984 final rule (49 FR 34767).

*Comment:* Many commenters stated that the actual Medicare outlay experience was far below the estimated outlays for the budget neutral period (FYs 1984 and 1985), and, therefore, hospitals were underpaid. Other commenters suggested that we should compare estimated payments for budget neutrality with actual outlays rather than incurred payments.

*Response:* Actual Medicare outlays are lower than estimated outlays because of a slow-down in the speed with which hospitals process bills and because of a decline in admissions. Although both factors affect estimated outlays, neither factor affects the determination of budget neutrality.

Budget neutrality, as provided for under section 1886(e)(1) of the Act, requires that outlays be the same under the prospective payment system as they would have been under the limits enacted under Pub. L. 97–248, that is, the law in effect prior to Pub. L. 98–21.

Budget neutral outlays should not necessarily equal the estimated outlays that appear in the budget for planning purposes. Thus, if actual outlays under budget neutrality are lower than estimated, they also would have been lower under the limits enacted by Pub. L. 97–248. Comparing estimated outlays with actual outlays provides absolutely no measure of the performance of budget neutrality.

In addition, we stated our intent in the addendum of the September 1, 1983 interim final rule (48 FR 39887) to determine budget neutrality on an incurred payment basis rather than a cash basis, and to assume that admission rates would be the same under the prospective payment system as under Pub. L. 97–248. We received no adverse comments on these provisions.

*Comment:* We received comments that our model does not reflect full experience under the prospective payment system and that we need cost report information to make these adjustments.

*Response:* It would be impractical to determine payments under the prospective payment system using current year cost reports, especially since we must set these rates before the cost report accounting years begin. Thus, we have used the best data and most recent information available to us in determining the payment rates.

*Comment:* We received comments stating that a shorter length of stay does not imply lower costs.

*Response:* Although this may be true in isolated instances, it is generally not the case. If such were the case, then there would be a zero marginal cost associated with longer stays, implying that our day outlier payment is excessive. Most hospitals see a financial advantage to a shorter length of stay, and are working to reduce length of stay in order to reduce costs.

c. *Corrections for Prior Years' Experience.*—(1) *Case mix.* In the proposed rule, the timeframes for the observed case-mix increase of 9.6 percent were based on prospective payment billing experience received through April 1985 for both FYs 1984 and 1985 combined. Using patient bill data received through July 1985, and using the FY 1984 relative DRG weights, we have determined that the average case-mix index for hospitals under the prospective payment system has increased 11.1 percent over the 1981 MEDPAR level. Relative to 1981, the average case mix increased 9.0 percent through FY 1984, and 11.1 percent through FY 1985. Since we now have significant experience for FY 1985 (4.7 million discharges), it would be more appropriate to use the FY 1985 experience than the combined experience, especially since FY 1985 is the basis for the prospective payment system in future years. We have previously taken 4.47 percent of this case-mix increase into account by adjusting the original FY 1984 standardized amounts by 3.38 percent and reducing the FY 1985 DRG weights by 1.05 percent. (The relationship of these percent changes is multiplicative, rather than additive; that is $1.0338 \times 1.0105 = 1.0447$.) Thus, the observed case-mix increase to date is 6.3 percent greater than the total prior adjustment (1.111 divided by $1.0447 = 1.063$).

*Comment:* Several commenters pointed out that the proposed rates make no allowance for real changes in case mix from 1981 through FY 1985, despite ProPAC's recommendation that an allowance for real increases in case mix that occurred during FY 1985 be incorporated in the FY 1986 rates.

*Response:* We disagree with the commenters' allegation for the following reasons. In FYs 1981 through 1983, prior to implementation of the prospective payment system, hospitals were reimbursed on a reasonable-cost basis which automatically made allowances for real changes in case-mix severity. Under the prospective payment system, for changes in real case mix that have occurred in FYs 1984 and 1985, as compared to 1981, we believe that an explicit add-on to the standardized payment rates would, in effect, result in the Medicare program paying for higher-cost, more resource intensive cases twice; first, by means of the specific add-on, and secondly, through the classification of the case in a higher-weighted DRG. To the extent that a hospital's case mix has changed because a greater proportion of cases are assigned to DRGs with higher weights, the provider has and will continue to receive increased prospective payments that reflect its real case mix. Therefore, a separate add-on to the standardized payment rates for real changes in case mix would not be appropriate.

In addition, we point out that under the budget neutrality provisions applicable for FY 1984 and FY 1985, any increases in case mix, whether "real" or attributable to changes in medical coding practices, should not have been recognized in increased prospective payments to hospitals. In the addendum to the proposed rule (50 FR 24393), we stated that, based on bills received through April 1985, the average case-mix index for hospitals under the prospective payment system increased 9.6 percent over the 1981 MEDPAR level. We now have data through July 1985, and the average case-mix index increased by 11.1 percent. Of this overall increase, only 4.47 percent was accounted for in budget neutrality reductions to the FY 1984 and FY 1985 prospective payment rates. Because budget neutrality is required by law and in view of the understatement of the FY

1984 and FY 1985 budget neutrality adjustments, a further 6.3 percent reduction in the standardized amounts of the prospective payment rates for FY 1986 is necessary to ensure that the first post-budget-neutrality payment rates are established on an appropriate basis. We reiterate, however, that even absent budget neutrality, we would want to make some adjustments for case mix in order to avoid overpaying for services.

*Comment:* Many commenters stated that we should not make any downward adjustments for increases in case mix that occurred in FY 1985 because increases in case mix would have been passed through under the Pub. L. 97–248 limits. They believe that any increases in real case mix would also been passed through under these limits.

*Response:* We agree that the limits under Pub. L. 97–248 would have passed through and did pass through a portion of the increase in real case mix. We will recognize increases in real case mix under the prospective payment system that occur in FY 1986 and later. To the extent that cases are falling into the higher-weighted DRGs, real case-mix increases will be automatically recognized and paid for under the prospective payment system. In addition, because the limits under Pub. L. 97–248 constituted a cost-based reimbursement system, increases in real case mix would have resulted in increased costs that would have been reimbursed subject to both the regulations describing the reasonable cost limits (§ 405.460) and the rate of increase limits (§ 405.463).

In modeling the limits under Pub. L. 97–248, we used cost-per-case increase assumptions that had a more than adequate margin for case-mix increases. Furthermore, we were careful to ensure that the cost-per-case increase assumptions did not reflect any of the incentives of the prospective payment system, such as a shorter length of stay. In fact, as described in the addendum to the June 10, 1985 proposed rule (50 FR 24393), we determined that the cost-per-case increase assumptions that we used in calculating budget neutrality in FYs 1984 and 1985 were too high. Thus, there was a liberal margin to allow for real case-mix increases under Pub. L. 97–248.

*Comment:* Some commenters stated that we removed all case-mix increases from 1981 through 1985, and that we are not allowing any real case-mix increases for 1981 through 1986. Other commenters requested that we remove all case-mix adjustments made in prior years.

*Response:* The model we used for determining budget neutrality under Pub. L. 97–248 implicitly allowed for all real case-mix changes that would have been allowed under Pub. L. 97–248 in FYs 1984 and 1985 as compared to the 1981 MEDPAR data. If we had not adjusted for the reported increases in case mix during the budget neutrality period, we would have paid double for increases in case mix (that is, first by means of overpaying for changes in case-mix due to improved medical coding, and secondly through classification of cases into higher-weighted DRGs). For this reason, and the reasons discussed in the previous comment, we cannot remove case-mix adjustments that we have already made (or we would be making excessive payments). We agree that real case-mix increases that occur during FY 1986 should be paid in full through classification of cases into higher-weighted DRGs, and we are not preventing increases in payments for real case-mix increases in FY 1986.

*Comment:* One commenter stated that our staff had acknowledged that unexpected case-mix increases would have been payable under Pub. L. 97–248.

*Response:* Unexpected real case-mix increases would have been partially recognized under Pub. L. 97–248, to the extent that case-mix increases resulted in increased costs per admission. An adequate margin for "real" case-mix increase was incorporated in the cost-per-case assumptions used in the determination of budget neutrality. Thus, if we were not to make a full adjustment for reported case-mix increases under the prospective payment system, we would, in effect, be paying double for increases in case mix.

*Comment:* Some commenters stated that the limits under Pub. L. 97–248 were adjusted for case mix and that exceptions were available.

*Response:* Sections 405.460 and 405.463 permit the granting of exceptions to the Pub. L. 97–248 cost limits and rate of increase limits based on changes in case mix. However, these exceptions are granted only on a limited basis and only where the provider can demonstrate that it has experienced an abrupt change in case mix due to the addition of new services or the discontinuance of previously provided services. Therefore, in the aggregate, changes in case mix under Pub. L. 97–248 would have little effect on total cash outlays since only a comparatively few hospitals will be granted increases in their Pub. L. 97–248 cost limits or rate of increase limits. To date, only a handful of exceptions have been granted. In addition, we do not believe the same incentives to improve coding of bills exist under the Pub. L. 97–248 limits since hospital payments are not dependent on the DRG to which a case is assigned.

*Comment:* Many commenters stated that we had abandoned the policy set forth in the addendum of the August 31, 1984 final rule (49 FR 34770) for allowing increases in real case mix. The commenters believe that the FY 1985 adjustment was binding in future years.

*Response:* As discussed previously, we have more than allowed for increases in real case mix even after we made adjustments for coding changes. The FY 1985 case-mix adjustment represented a discretionary policy decision that was made for FY 1985 pending further studies of case-mix data. This decision, made in consultation with the hospital industry, represented a delay to the full reduction for nominal (improved medical coding) case mix until a study of the nature of the case-mix increases was completed. This study, now completed by the Rand Corporation, supports a full reduction for nominal case-mix increase that occurred prior to publication of the FY 1986 prospective payment rates. This study found that, since 1981, only a small portion of the reported case-mix increases are "real". As discussed previously in this section, the cost-per-case assumptions, used in developing the budget neutrality adjustments in prior years, provided an adequate margin for "real" case-mix increases.

*Comment:* Many commenters objected to the adjustments we made to refine the FY 1985 base, such as adjustments for case mix and market basket forecasts. As well, many commenters objected to what they referred to as the retroactive nature of the adjustments, and to our using budget neutrality to adjust for case mix. Other commenters stated that we had destroyed the prospective nature of the prospective payment system. Quoting section 1886(e)(4) of the Act,

> Taking into consideration the recommendations of the Commission, the Secretary shall determine for each fiscal year (beginning with fiscal year 1986) the percentage change which will apply for purposes of this section as the applicable percentage increase (otherwise described in subsection (b)(3)(B) for discharges in that fiscal year, and which will take into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality.

these commenters claimed that we violated this section of the law.

*Response:* In order to comply with section 1886(e)(4) of the Act, we adjusted the prospective payment change factor to compensate for FY 1985 payments being excessive. Though this adjustment, in the sense of looking back, may have been retrospective, it certainly was not retroactive. We have not

destroyed the concept of prospectivity since we are not recovering overpayments or refunding underpayments nor have we reduced rates so as to effect recovery of overpayments during FY 1986. Rather, we are ensuring that payment levels for FY 1986 will be adequate for the appropriate and necessary care of Medicare beneficiaries. There is no statutory requirement to establish rates so as to perpetuate estimating errors, whether upward or downward, indefinitely into the future. Also, there is no statutory provision prohibiting us from correcting past estimating errors. We made reference to budget neutrality in adjusting for case mix because budget neutrality applied in FY 1985, and FY 1985 is the basis for all future prospective payments. We have not received any evidence or studies suggesting that the prospective payment rates are inadequate so as to preclude the hospital industry from providing Medicare beneficiaries with high quality, medically appropriate care. In addition, as we have already noted, we would have had to make these adjustments even in the absence of budget neutrality in order to comply with section 1886(e)(4) of the Act.

*Comment:* We received comments stating that we should separate the FY 1985 case-mix increase into real increases and coding increases. Other comments suggested that we had acknowledged that we were unable to separate the reasons for case-mix increases.

*Response:* A study performed by RAND provided this analysis for us. For purposes of FY 1985, in which budget neutrality applied, separating real case-mix increases from increases resulting from improved coding is unnecessary since the limits enacted by Pub. L. 97-248 did not pass through increases in reported case mix, and since the cost-per-case assumptions used to determine budget neutrality more than allowed for real increases in case mix.

*Comment:* Several commenters were critical of the study conducted by the Rand Corporation to determine the reasons for the increase in the Medicare case-mix index since 1981. That study concluded that, of the 8.4 percent increase in the case-mix index observed from calendar year 1981 through FY 1984, 6.2 percentage points, or almost three-quarters of the increase, were due to documentation and coding changes. (Subsequent to the completion of this study, RAND has revised the 8.4 percent figure to 11.3 percent based on bills received through April 1985.) The study concluded that since coding changes were responsible for a large portion of the case-mix increase experienced to date, these changes should be reflected in an adjustment (that is, an offset) to eliminate the effect of nominal (improved coding) case-mix increases (as opposed to "real" changes) in the determination of the prospective payment rates. One commenter stated that the Rand study did not use an appropriate time series design and that the only experimental design that would have permitted an assessment of the effects of real changes in case mix from changes in coding would have been a reabstracting study. We received other comments that the study failed to address the issue of whether the sharp increase in the case-mix index could have been at least partially attributed to the significant decline in Medicare admissions since the beginning of the prospective payment system. The implication is that those DRGs with a low weight may have had a disproportionate share of the decline in admissions due to the furnishing of care on an outpatient or other basis. The impact of such an effect would be an understatement of approximately 25 percent of the observed 8.4 percent increase in case mix considered "real."

*Response:* As we stated previously in this section, any increases in case mix prior to FY 1986, whether "real" or not, should not be recognized in increased FY 1986 prospective payments because of the budget neutrality requirement that applies through FY 1985. Furthermore, we disagree with the statement that the only experimental design that would have allowed an accurate determination of the reasons for the substantial increase in the case-mix index is a reabstraction study. Because RAND examined the increase in hospital case mix for facilities with different reporting periods from calendar year 1981 through FY 1984, a time series analysis was reflected in the experimental design. We point out that a time series analysis of data from the Commission on Professional and Hospital Activities was performed by RAND. This design enabled RAND to distinguish coding improvements from the estimated effects due to "real" increase in the case-mix index. Therefore, a reabstraction study is not essential in distinguishing real from nominal increases in case mix.

Furthermore, a reabstracting study would not capture the effect of improved documentation of diagnoses and procedures by physicians. Thus, reabstracting is unnecessary, and, if done, would not be definitive.

An examination of case-mix changes that have occurred in the four waiver States (New York, New Jersey, Maryland, and Massachusetts) provides further evidence that a significant portion of the increase in the case-mix index reflects prospective payment system-induced changes in coding and medical practice. Since the four waiver States either do not use DRGs for reimbursement, or place less emphasis on them than the prospective payment system, comparing their case-mix index rate of change to that of hospitals in the non-waiver States over the same period of time would provide a rough measure of the magnitude of prospective payment system-induced coding improvements. Also, because the waiver States are subject to the same changes in medical technology and the impact of changes in the patient population as the rest of the country, such a comparison should reveal the extent to which the prospective payment system has affected nominal changes in case mix. At our request, the Rand Corporation performed such an analysis. As the table below reveals, Medicare data show an 8.4 percent increase in case mix in the non-waiver States from calendar year 1981 to FY 1984, while the corresponding increase for the waiver States was only 2.0 percent. A similar analysis was performed on the Professional Activity Study (PAS) data (discharge abstract data collected by the Commission on Professional and Hospital Activities) from the fourth quarter of 1981 to the fourth quarter of 1984. This analysis revealed the case-mix index increased by 5.9 percent in the non-waiver states but only 0.3 percent in the waiver States. These comparisons provide further evidence that much of the observed case-mix index increase reflects prospective payment system-induced changes in coding.

CASE-MIX INCREASE IN WAIVER STATES

| | Percent change, 1981-1984 | |
|---|---|---|
| | Non-waiver | Waiver |
| Medicare data [1] | 8.4 | 2.0 |
| PAS data [2] | 5.9 | 0.3 |

[1] Calendar Year 1981 to Fiscal Year 1984.
[2] Fourth Quarter of Calendar Year 1981 to Fourth Quarter Calendar Year 1984.

We also asked RAND to investigate whether the sharp decline in Medicare admissions from 1983 to 1984 may have contributed to the increase in the case-mix index (although, as we note elsewhere in this section of the addendum, Medicare admissions did *not* decline during the period 1981 through 1984). A reduced demand for hospital services at the same time the

prospective payment system was being implemented could have led to an understatement of the rate of increase in case mix that was real if it led to an increase in the complexity of the admissions that occurred. A regression model that explicitly included volume changes was performed on the Professional Activity Study data. RAND found that the magnitude of the volume effect was very small. For example, a four percent decline in admissions is estimated to have increased case mix by only 0.2 percent in FY 1984. Therefore, controlling for volume changes did not alter the significance of the conclusion that most of the observed change in case mix is due to changes in medical coding.

Finally, in response to the assertion that a significant portion of the 8.4 percent increase in case mix that RAND observed may be attributed to a shift in the proportion of cases falling in DRGs with relatively low weights from an inpatient to an outpatient setting, RAND selected 37 DRGs having a significant potential for outpatient substitution to determine their contribution to the increase in the case-mix index. The 37 DRGs accounted for only 0.7 percent of the 8.4 percent increase, and virtually all of that 0.7 percent was accounted for by DRG 39 (lens procedures). In response to further comments that several DRGs with a high potential for outpatient substitution were not included in the analysis, 3 DRGs were added to the original 37 initially selected. They are DRGs 364, 410, and 412. The three were dominated by category 410 (chemotherapy), which *increased* as a proportion of Medicare discharges under the prospective payment system. Because DRG 410 has a relatively low weight, the increased proportion of Medicare discharges tended to lower the case-mix index. Thus, with an expanded list of outpatient DRGs, the portion of the case-mix index increase attributed to a shift in cases to outpatient settings (that is, the portion that reflects "real" increase in the case-mix index) was somewhat reduced. This result further supports the finding that most of the increase in the case-mix index that RAND observed reflected changes in medical coding practices.

*Comment:* Many commenters stated that reduced admissions and the movement of certain cases to an outpatient setting would increase case mix leaving hospitals with more severely ill patients. One commenter supplied evidence purporting to show that patients are more severely ill because fewer patients can get out of bed unassisted and because hospitals have increased the number of employees per bed on their staffs. One commenter suggested that shortening the length of stay did not reduce the cost per admission. We also received comments that the prospective payment system was the cause for fewer admissions.

*Response:* We agree that a reduction in admissions could increase case mix. The RAND study measured the increase in case mix due to the shifting of cases to the outpatient setting. The cost-per-case assumptions used in the determination of budget neutrality more than compensated for these increases in case mix. It is not surprising that a higher percentage of patients are unable to get out of bed unassisted. Shortening the length of stay can lead to this situation, since the days removed from the stay are the latter days, when the patient is more mobile. This does not imply that such shortened admissions are more costly. The staffing level in a hospital has not been shown to be a reliable indication of the severity of illness of the patients. As one commenter stated, "physicians, not hospitals, admit patients and hospitals do not determine the location of treatment." We agree, therefore, that the prospective payment system does not appear to have an impact on the number of admissions.

We refer the reader to the discussion in the previous comment and response of the RAND regression analysis, which included volume changes. The results of this analysis showed that volume changes had little impact on case mix.

*Comment:* We received comments that admissions have declined substantially since 1981. One commenter supplied evidence showing that admissions declined since 1983.

*Response:* Panel Survey Data published by the American Hospital Association do not show Medicare admissions declining during the period 1981 through 1984. Admissions declined from 1983 to 1984 because 1983 was a year with an unusually high Medicare admission level. However, Medicare admissions still increased substantially during the period 1981 through 1984.

*Comment:* Some commenters suggested that we simply dismissed the effect of aging on average case mix, and that costs within a DRG increase with age.

*Response:* The DRG. system considers age when assigning a DRG. Consequently, the aging of the population should have minimal impact on costs within a DRG. In addition, the RAND study estimated the effect of the aging of the inpatient population through calculating case-mix indexes by age group and by the proportion of Medicare discharges in each age group in 1981 and 1984. As a check, RAND calculated the case-mix indexes by age group using both 1981 and 1984 data.

As shown in the table below, aging did not affect the case-mix index. Calculating the case-mix indexes by age group from 1981 data, the 1984 age distribution would have resulted in a 1981 case-mix index of 1.0490, which is close to the actual 1981 case-mix index of 1.0486. Similarly, the 1981 age distribution would have resulted in a 1984 case-mix index of 1.1183, which is close to the actual 1984 case-mix index of 1.1181. Therefore, the aging of the Medicare population has had a negligible impact on the observed increase in case mix.

AGE OF MEDICARE INPATIENTS AND THE CASE-MIX INDEX (CMI)

| Age group | 1981 | | 1984 | |
|---|---|---|---|---|
| | Percent | CMI | Percent | CMI |
| <65 | 11.91 | 1.0356 | 11.30 | 1.1063 |
| 65 to 69 | 22.45 | 1.0386 | 21.17 | 1.1233 |
| 70 to 74 | 21.61 | 1.0633 | 21.05 | 1.1404 |
| 75 to 79 | 18.55 | 1.0511 | 19.41 | 1.1176 |
| 80 to 84 | 13.89 | 1.0444 | 14.43 | 1.0972 |
| 85 + | 11.78 | 1.0555 | 12.65 | 1.1065 |
| Total | 100.00 | 1.0486[1] | 100.00 | 1.1181 |

Source: Medicare data, nonwaiver states.

[1] The Medicare case-mix index, which was based on MEDPAR data for calendar year 1981, was 1.046. The slight difference between the value of this case-mix index, and that appearing in the above table, is due to cases with missing DRGs.

Moreover, both our studies and the RAND study have determined that the aging of the Medicare population has had negligible impact on the increase in case mix.

*Comment:* A commenter suggested that we should use RAND's 8.4 percent case-mix increase instead of our proposed 9.6 percent increase.

*Response:* As explained in the addendum to the proposed rule (50 FR 24393), we used the 9.6 percent increase because it was based on more recent data and included not only FY 1984

data, but also FY 1985 data. Additional data received since the NPRM was issued show that case mix has now increased by 11.1 percent.

When RAND updated its data to include FY 1984 claims that were received well into FY 1985, they concluded that the case-mix index for FY 1984 increased 9.2 percent. Similarly updated RAND data project that the case-mix index for FY 1985, for claims received through April 1985, increased 11.3 percent.

*Comment:* Many commenters complained that we did not describe the methodology used to calculate the case-mix increases, and that we did not specify the timeframe to which these increases applied.

*Response:* The methodology used to compute the case-mix increase is the same methodology used and fully described in the July 3, 1984 proposed rule (49 FR 27442) and in the August 31, 1984 final rule (49 FR 34770). To summarize, for each hospital, and for each month, the case-mix level in the 1981 MEDPAR file for the corresponding month is weighted by the prospective payment system discharges for the month. Then, all months of the 1981 MEDPAR file are weighted together. This is divided into the average case-mix under the prospective payment system to compute the case-mix increase. This method automatically adjusts for seasonal variations in case-mix, for the different rates at which hospitals submit bills, and for the phasing in of hospitals to the prospective payment system by accounting year. In the proposed rule, the timeframe for the case-mix increase was the total prospective payment system experience, including bills we received through April 1985, for both FYs 1984 and 1985. Looking at the experience as reflected through bills received through July 1985, we now have prospective payment system case-mix experience on 5.8 million discharges in FY 1984 and 4.7 million discharges in FY 1985. Relative to 1981, the average case-mix index increased 9.0 percent through FY 1984, and 11.1 percent through FY 1985. Since we now have significant experience for FY 1985, it would be more appropriate to use the FY 1985 experience than the combined experience, especially since FY 1985 is the basis for the prospective payment system in future years.

*Comment:* One commenter alleged that we cut reimbursement upon observing that the average case weight had increased to a level in excess of 1.000.

*Response:* We disagree with the commenter's allegation and note that the average case weight in the MEDPAR file was on a discharge-weighted basis of about 1.05.

*Comment:* Many commenters stated that the law requires us to consider the most recent case-mix data available.

*Response:* We agree with the commenters. We have considered the most recent case-mix data available and have determined that corrections need to be applied. Further, we have made every effort to acquire and analyze the latest possible case-mix data.

*Comment:* We received comments that stated that we must consider case-mix changes when recalibrating the relative DRG weights.

*Response:* In fact, we were careful to ensure that average case weight using both the old set of weights and the new set of weights is the same. This "normalization" of the recalibrated weights had the effect of increasing all the recalibrated weights by three percent. Therefore, had we not taken care to provide for normalization, all the recalibrated weights would be lower. We did not use the recalibration to adjust for changes in case mix.

**Summary of Case Mix Discussion**

Many comments reflect confusion over whether and to what extent increases in case mix would have been recognized and paid for under Pub. L. 97-248. Because the case-mix index is, by definition, a measure of a hospital's average cost per case relative to the average of all hospitals' average costs per case (as described in the September 1, 1983 interim final rule (48 FR 39764)), the only changes in case mix that would have been recognized under Pub. L. 97-248 are "real" changes in case mix, since it is only real changes in case mix that affect a hospital's average cost per case.

Because aggregate outlays under the prospective payment system were required to be neither greater nor less than what outlays would have been under the Pub. L. 97-248 limits, it was necessary to estimate expected reimbursement levels under both Pub. L. 97-248 and the prospective payment system, and to set the prospective payment rates at a level that would result in equality between outlays under Pub. L. 97-248 and the prospective payment system.

Hence, for purposes of budget neutrality, it was assumed that under Pub. L. 97-248, Medicare costs per case would have increased at the following rates:

*Estimates used to set fiscal year 1984 and fiscal year 1985 rates*

| | Percent |
|---|---|
| 1983 | 10.9 |
| 1984 | 9.8 |
| 1985 | 9.8 |

(See the August 31, 1984 final rule at 49 FR 34798 and the June 10, 1985 NPRM at 50 FR 24395.)

These assumptions implicitly incorporated increases in hospital input prices, changes in technology, increases in the intensity of services provided to hospital inpatients, increases in real case mix (which, by definition, result in increases in costs), and other factors.

One can remove the effects on cost per case of inflation by use of the most recent market basket factors, which are:

| | Percent |
|---|---|
| 1983 | 6.3 |
| 1984 | 5.7 |
| 1985 | 4.8 |

Thus, the extent to which cost-per-case estimates exceeded hospital industry inflation is:

| | | |
|---|---|---|
| 1983 | 4.3% | (1.109÷1.063=1.043) |
| 1984 | 3.9% | (1.098÷1.057=1.039) |
| 1985 | 4.8% | (1.098÷1.048=1.048) |

These increases in the cost per case (over and above inflation adjustments) that we estimate would have occurred under Pub. L. 97-248 are, we believe, more than ample allowances for increases in real case mix and changes in technology, intensity, and utilization of inpatient services. Indeed, as noted elsewhere, we conclude, on the basis of actuarial estimates, that the cost-per-case assumptions used in setting the prospective payment rates to date have resulted in an overstatement of the FY 1985 rates of approximately 1.2 percent. Nevertheless, we are not including an offset for this overstatement in our composite correction factor. However, because we believe that the FY 1985 rates already include a generous margin for changes in real case mix, we believe it is wholly appropriate to include in our composite correction factor a full adjustment for reported case-mix increases not previously accounted for.

In summary, we believe it is essential to adjust the FY 1985 standardized amounts to remove the effects of all previously unaccounted for increases in case mix, whether "real" or coding-related, for the following reasons:

• Unaccounted for increases in case mix resulted in FY 1985 standardized rates that were overstated. Under budget neutrality, these increases in case mix should not have increased payments to hospitals.

• As described in the August 31, 1984 final rule (49 FR 34773) and the June 10, 1985 proposed rule (50 FR 24393), our estimates of cost-per-case increases for budget neutrality purposes that would have occurred during FYs 1984 and 1985 under Pub. L. 97–248 incorporated an implicit recognition of case-mix increases that would have occurred regardless of implementation of the prospective payment system. (This included recognition that the Pub. L. 97–248 cost-per-case group limits were also case-mix adjusted, so that increases in case mix would have been reflected in those limits to the extent they had an impact on hospital costs.) Since the same incentives to improve coding would not exist under Pub. L. 97–248, this margin would essentially represent potential real case-mix increases as opposed to coding-related increases.

• Therefore, since a margin for real case-mix increases has already been incorporated in the standardized amounts through the cost-per-case assumptions used in determining the budget neutrality adjustment for FY 1984 and FY 1985, we would be recognizing real case-mix increase twice in the prospective payment rates if we failed to make adjustments for all reported case-mix increases.

• Hospitals have already received the benefit of both real case-mix increases as well as coding improvements. To the extent that future case-mix increases are real, these will be paid through assignment of cases to the higher weighted, more resource-intensive DRGs.

• The results of the RAND study demonstrated that much of the observed increase in case mix was due to prospective payment system-induced coding improvements. Since the cost-per-case assumptions used to determine budget neutrality in FY 1984 and 1985 already more than allowed for those increases in case mix which are real to be incorporated in the prospective payment rates, it is appropriate to adjust for all reported increases in case mix whether "real" or coding-related.

(2) *Market basket.* The forecasted hospital market basket increase factors used to calculate the FY 1985 standardized amounts were 6.2 percent for 1983, 6.0 percent for 1984, and 6.5 percent for 1985. Our latest hospital market basket factors, as of July 1985, reflect more actual experience than those available at the time the FY 1985 rates were published. The most recent factors are 6.3 percent for 1983, 5.7 percent for 1984, and 4.8 percent for 1985. Substituting these latest market basket factors into our budget neutrality model for correction of the standardized amounts reduces them by 1.2 percent.

We are not making retroactive adjustments. We believe that there is ample statutory authority to correct previous market basket forecasting errors *prospectively.*

*Comment:* Many commenters stated that we had promised not to revise the market basket for projection errors. Some commenters opposed any revisions in the market basket while others supported the concept of revisions in the market basket projections. ProPAC suggested that, because only the third quarter of the fiscal year would have elapsed when the market basket projection was determined in this addendum, we wait another year, or that we make corrections for the first three quarters of the fiscal year and then correct the fourth quarter in the following year.

*Response:* To maintain the integrity of the prospective payment system, we must have an appropriate base upon which payment levels are set. Since FY 1985 is the basis for future year payment rates, any market basket projection errors in FY 1985 would be carried forward into all future years. Therefore, based on the recommendation of ProPAC and other commenters, we decided to use a more recent update (the latest data available) of the market basket to develop a more accurate payment basis. We are revising the market basket estimate only for forecast changes and are not making any changes in the market basket itself.

If we were to revise the market basket estimates to reflect only actual experience through June 1985, and not to reflect the most recent estimates available, we could be forced to make even larger changes in the market basket update factor in next year's prospective payment rate notice. We believe that it is in the best interests of the hospital industry, therefore, to reflect changes in the market basket estimates using the latest estimates available at the time we issue the annual prospective payment notice.

*Comment:* Several commenters stated that we should adjust the market basket, but that the changes should not be applied retroactively.

*Response:* We agree that the market basket forecast changes should not be applied retroactively. Hence, we are not making any recoveries for overpayments for FYs 1984 and 1985.

*Comment:* Many commenters stated that we should acknowledge that FY 1986 is not a budget neutral year.

*Response:* We agree that FY 1986 is not a budget neutral year. However, budget neutrality is a consideration because FY 1985 is the base year for future prospective payment system payments, and because budget neutrality applied in FY 1985. Because payments in FY 1985 were higher than they should be under budget neutrality, we are correcting the update factor for FY 1986 to ensure that payment levels are not distorted in all future years.

*Comment:* Many commenters wanted documentation on the 1.3 percent difference in the forecasted market basket projections.

*Response:* The 1.3 percent difference represents the difference between the standardized amounts, holding the budget neutrality adjustment factor constant, by comparing the FY 1985 market basket forecast with our revised market basket forecast as discussed in the addendum to the proposed rule (50 FR 24394). The actual difference in the market basket updates (as documented at the beginning of this section) is actually greater than 1.3 percent. However, because actual costs are a factor in budget neutrality, only part of the difference in the updated market basket is reflected in the impact on budget neutrality. The latest market basket update for FY 1985 increased 0.1 percent since the February update, and consequently, we revised the adjustment to −1.2 percent.

(3) *Additional causes for the overstatement of FY 1985 Federal rates.* In addition to the factors above, which we believe we must correct, other considerations also contributed significantly to the overstatement of the FY 1985 standardized amounts.

When we set the standardized amounts for FY 1985, we made assumptions on hospital cost per case increases in order to estimate, for purposes of budget neutrality, the payments that would have been made had prior payment rules continued in effect. These assumed rates of increase in cost per case were 10.9 percent for 1983, 9.8 percent for 1984, and 9.8 percent for 1985. These assumptions were significantly higher than the actuarial estimates. The actuarially estimated rates of increase in cost per case (which ignore any effects of the prospective payment system such as shorter lengths of stay) are 9.8 percent for 1983, 8.1 percent for 1984, and 8.5 percent for 1985. After application of the revised market basket, discussed previously, use of these actuarial

estimates would reduce the standardized amounts by an additional 1.2 percent.

For FY 1985, we also used 1981 unaudited, as-submitted cost reports (to get recent data as quickly as possible) to set the Federal rates. The hospital-specific rates were set using later (1982 or 1983) cost reports that were fully audited. The audits adjusted the total cost for these reports downward by $2.2 billion, of which Medicare realized about $900 million in inpatient recoveries. Since the cost data used to set the Federal rates do not reflect audit recoveries, it is likely that they are overstated by a similar amount. We do not know precisely what proportion of this amount applies to capital-related costs and other costs that would not affect the Federal rates. However, approximately 90 percent of hospitals' total inpatient costs are operating costs, and if only 40 percent of the $900 million in audit recoveries is related to Federal payments for inpatient operating costs, there would have been, conservatively estimated, at least a one percent overstatement of allowable costs incorporated into the cost data to determine the FY 1985 standardized amounts.

In addition, the General Accounting Office (GAO) recently conducted a study to evaluate the adequacy of the standardized amounts. In its report to Congress dated July 18, 1985 (GAO/HRD-85-74), GAO reported findings that the standardized amounts, as originally calculated, are overstated by as much as 4.3 percent because they were based on unaudited cost data and include elements of capital costs. GAO recommended that the rates be adjusted accordingly.

We believe that these causes for the overstatement of the standardized amounts are related to our own procedures and decisions. Thus, they are unlike both the market basket index, which is a technical measure of input prices, and the increases in case-mix, which would not have been passed through beyond the extent to which they affected the estimates of cost per case. Further, as discussed below, even without making these corrections, we could justify a negative update factor for FY 1986, although we are not establishing one. Since we have decided to set FY 1986 standardized amounts at the same level as those for FY 1985, making corrections now to reflect the cost per case assumptions and the audit data would have no practical effect. Therefore, we have decided at this time not to correct the standardized amounts for these factors.

We received no comments on this issue.

(4) *Composite Correction Factor.* We are adjusting the standardized amounts as follows to take into consideration the overstatement of the prior years, amounts:

| | Percent |
|---|---|
| Case mix | −6.3 |
| Market basket | −1.2 |
| Composite correction factor | −7.5 |

d. *Forecast Market Basket Increase.* We considered forecasted market basket index increases in determining the percentage increase for both prospective payment rates and rate-of-increase limits for FY 1986 and subsequent fiscal years. However, the percentage change determined under section 1886(e)(4) of the Act does not have to equal the market basket index plus one quarter of one percentage point, although section 1886(b)(3)(B) of the Act does specify that for FY 1986 the percentage determined under section 1886(e)(4) of the Act *may not exceed* the applicable percentage increase that would otherwise be determined for that period.

FORECASTED MARKET BASKET (MB) PERCENT INCREASE PLUS ONE-QUARTER OF 1 PERCENTAGE POINT

| Calendar year | MB percentage | MB + ¼ percentage |
|---|---|---|
| 1985 | 4.8 | 5.05 |
| 1986 | 4.1 | 4.35 |
| 1987 | 4.8 | 5.05 |

Based on these calendar year factors, we project a hospital market basket increase factor for FY 1986 (that is, October 1, 1985 through September 30, 1986) of 4.27 percent. Thus, the maximum update factor we could use in updating the FY 1986 standardized amounts (that is, the market basket plus one-quarter of one percentage point) would be 4.52 percent.

*Comment:* One commenter suggested that HCFA should not use the most current Data Resources, Inc. forecast of the market basket, because it incorporates the assumption that an update of zero percent of the prospective payment rates may take place in FY 1986. In particular, the commenters believe that the zero percent update could influence the pattern of hospital wage setting, and that Data Resources, Inc. may incorporate such changes in patterns of wage setting in its forecasts.

*Response:* The market basket forecast (4.85 percent) stated in the NPRM did not incorporate as an assumption that we were proposing a zero percent increase to the prospective payment rates. However, the most recent market basket forecast (4.27 percent) does incorporate changes resulting from the prospective payment system.

In addition, for the reasons stated below, we believe that incorporating these changes is appropriate. A primary objective of the prospective payment system is to alter the incentives of Medicare payment to encourage efficiency and effectiveness. Improvements in the processes of hospital purchasing, operations, quality control, practice patterns, etc., were desired and anticipated by Congress. The intent is to adjust the prospective payment rates to reflect these changes in behavior under the prospective payment system. For instance, the congressionally mandated recalibration of individual DRG rates is a demonstration of the intent to adjust for behavioral changes associated with the prospective payment system.

To most accurately capture the unique labor market characteristics of the hospital industry, and to be consistent with the use of the area wage index to adjust the standardized amounts for geographic area wage cost differentials, we use a hospital industry wage rate in our market basket.

During the last four calendar years, average hourly earnings in the hospital industry have increased at rates substantially in excess of economy-wide wage increases (see table below). The hospital wage rate we use captures the effects of skill-mix and occupation-mix shifts in the hospital industry, because it is measured by payroll expenses divided by hours of work. If case mix becomes more severe as a result of behavioral changes associated with the prospective payment system, and it becomes medically appropriate to shift to a higher quality and skill level of employees, the hospital wage variable we use captures observed behavioral changes to upgrade the skill-mix of employees. Likewise, if hospitals respond to a decrease in hospital admissions and lengths of stay, laying off workers with less seniority and associated lower wages, the hospital wage variable we use captures the upward pressure on average hourly earnings.

CALENDAR YEAR (PERCENTAGES)

| | 1981 | 1982 | 1983 | 1984 |
|---|---|---|---|---|
| Hospital industry wage rate increases used in the prospective payment market basket | 12.3 | 11.2 | 7.4 | 5.5 |
| Economy-wide wage rate increases (Index of Hourly Earnings of Production Workers—total private nonfarm), Bureau of Labor Statistics | 9.1 | 6.9 | 4.6 | 3.4 |

An intended effect of the prospective payment system is to encourage hospitals to be prudent buyers of labor using state-of-the-art wage and salary administration procedures used in other sectors of the economy.

Forecasts of hospital wage increases, and other components of the hospital market basket, as provided by the private consulting firm of Data Resources, Inc. include their best estimates of the combined forces expected over the period 1985 to 1987. Since forecasting is inherently difficult and subject to error, we will prospectively correct for forecast errors.

In summary, we feel our treatment of hospital wages in the market basket is appropriate and makes specific allowance for quality and skill level of employees as shifts are made in response to prospective payment system incentives.

*Comment:* One commenter stated that we did not supply any of the supporting information on which the FY 1986 hospital market basket projections were based.

*Response:* The market basket components, relative weights as well as the data source for each component measure, are listed in the September 1, 1983 interim final rule (48 FR 39845). Also, referenced in the rule as a source for further background on the development of the market basket index is an article by Freeland, Anderson and Schendler, "National Hospital Input Price Index," *Health Care Financing Review*, Summer 1979. In addition, Data Resources, Inc., which is the forecaster of the market basket increases, is specifically identified. The addresses for Data Resources, Inc. are also provided in the September 1, 1983 document for anyone interested in obtaining additional information on these forecasts. Upon request, Data Resources, Inc. will provide in writing a description of the general methodology as well as a discussion of the variables considered in developing the market basket forecasts. Because this information continues to be available to the public, we believe we have supplied the public with sufficient information concerning the development of the market basket forecasts, including specific data sources for interested parties. As pointed out previously, because of the limited interest that these data would have for the majority of readers, it is not our policy to publish the voluminous amount of data associated with the various factors developed for the prospective payment system. However, we note that this does not imply that the information is unavailable to the public upon request.

e. *Composite Policy Target Adjustment Factor—(1) General considerations.* In analyzing the prospective payment system [1] we considered the effects of the rates we set on outcomes such as quality of health care, access to care, and the financial viability of the hospital industry. The annual prospective payment percentage increase factor should be set so that it provides incentives for desired outcomes under the prospective payment system. To achieve incentives for the desired outcome targets, we must ensure that the annual prospective payment update factor takes proper account of variables affecting the cost, efficiency, effectiveness and quality of production of hospital inpatient care. Our objective is to translate the intent of the statutory requirements for updating the prospective payment rates into a methodology for making adjustments to the current update factor that would enable us to express our consideration of these variables as policy targets.

To this end, we have identified three factors that correspond to matters that must be considered under sections 1886(e)(2) and (e)(4) of the Act. For FY 1986, we are incorporating into the prospective payment update factor a composite "policy target adjustment factor" that takes account of productivity (efficiency), cost-effective technologies, and cost-ineffective practice patterns. Although, for the purposes of analysis and discussion, we have developed separate values for each of these three factors, we are combining them into a composite policy target adjustment factor, which we used in determining the FY 1986 prospective payment update factor.

*Comment:* Several commenters suggested there was lack of data or data known only to us that were used in the development of the policy target adjustment factors. In particular, one commenter asserted an inability to comment on the productivity adjustment because the BLS productivity indexes were not adequately identified.

*Response:* HCFA and ProPAC were fully aware that there were not as many data available on the update factors as would be preferred. On the other hand, both HCFA and ProPAC also agreed that sufficient data were available on the public domain to make estimates to carry out the congressional intent to consider and account for the effects of productivity, new technologies, and other factors. These data sources and related studies are specifically cited in Appendix B of the June 10, 1985 proposed rule (50 FR 24440) or in the Technical Appendix of the ProPAC Report to the Secretary. The BLS indexes used to develop the productivity adjustment were those cited in the "Current Labor Statistics" section of the *Monthly Labor Review* of the U.S. Department of Labor, BLS. These are readily available to the public and were not cited specificially in Appendix B of the NPRM because of our assumption that the availabitiy of government data was generally known. Currently there is no specific productivity measure for hospitals; however, BLS is in the process of developing such a measure. In developing the productivity adjustment, we benefited from discussion with BLS staff on productivity measures.

Our add-on for cost-effective new technologies of 1.5 percent takes into account the congressional intent for continued growth in intensity of services associated with new technologies and scientific advances. It is important to note that capital-related costs for new technologies continue to be paid for on a retrospective cost basis. The new technologies factor is for operating expenses only. HCFA's 1.5 percent add-on for new technologies is within the range recommended by ProPAC for its factor "Scientific and Technological Advances."

[1] In determining how to implement the requirements of sections 1886(e)(2) and (e)(4) of the Act, we have adopted an analytic framework developed by the Division of National Cost Estimates of HCFA's Office of the Actuary. A technical explanation of this framework was issued as Appendix B of the proposed rule (50 FR 24440). A revised version of Appendix B will be appearing in the Fall 1985 *Health Care Financing Review* in the Legislative Update section.

ProPAC recommended two offset factors: Hospital Productivity (−1.5 to −2.0 percent) and Changes in Hospital Product (−1.0 percent). Combined, these two offset factors equal −2.5 to −3.0 percent. ProPAC's "Changes in Hospital Product" factor is included within HCFA's "Ineffective Practice Pattern Offset" factor. Using essentially the same publicly available data sources, ProPAC and HCFA derived similar estimates for the combined offsets. Our combined offset was ×3.0 percent; whereas, ProPAC's was −2.5 to −3.0 percent. The analytical framework that we incorporated contributed to a different interpretation and split between the two ProPAC offset factors, with HCFA allocating relatively more emphasis to the changes in the hospital product factor and less to the hospital productivity factor.

Both HCFA and ProPAC concur that as more data become available, we can incorporate it to improve the update adjustment factors. Likewise, in order to meet congressional intent, both HCFA and ProPAC also agree that more clear-cut methodologies must be developed. The interactions among the factors and the difficulty of disentangling these factors from other factors contributing to cost increases require that judgment will be necessary.

*Comment:* Some commenters suggested that because we did not use terminology identical to ProPAC, we did not adequately consider ProPAC's analyses and recommendations.

*Response:* HCFA began its study of the prospective payment rate increase factor by carefully examining section 1886(e)(4) of the Act, which we quoted in the proposed rule (50 FR 24392). Section 1886(e)(4) of the Act reads as follows:

> (4) Taking into consideration the recommendations of the Commission [that is, ProPAC] the Secretary shall determine for each fiscal year (beginning with fiscal year 1986) the percentage change which will apply for the purposes of this section as the applicable percentage increase (otherwise described in subsection (b)(3)(B)) for discharges in that fiscal year, and which will take into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality.

Further, as prescribed by section 1886(e)(2) of the Act, the Commission, in making its recommendations to the Secretary,

> . . . shall take into account changes in the hospital market-basket described in subsection (b)(3)(B), hospital productivity, technological and scientific advances, the quality of health care provided in hospitals (including the quality and skill level of professional nursing required to maintain quality care), and long-term cost-effectiveness in the provision of inpatient hospital services.

We believe that our framework more accurately captures the congressional intent of the statute than does ProPAC's formulation. For example, section 1886(e)(4) of the Act specifically states that the effectiveness dimension of health care delivery be considered and accounted for in the percent increase factor. Further, we believe that our framework has a substantially stronger analytical basis than the ProPAC formulation. Our framework incorporates ProPAC's factors where they are specifically included in the statute. We believe that ProPAC made important conceptual and quantitative contributions to our understanding of the percent increase factor. However, we used different terminology, such as policy target adjustment factor rather than the discretionary adjustment factor, for two reasons:

- To more accurately characterize our framework and the decision-making process, and
- To reduce confusion between our framework and ProPAC's approach, since they differ, as mentioned above.

Some commenters made recommendations for changing some of the terminology used in describing the policy adjustment target factors. We are now considering certain changes in terminology as a result of these comments. Some examples are changing "productivity offsets" to "productivity improvements," and changing "cost-effective practice patterns" to "clinical practice pattern improvements."

*Comment:* Some commenters suggested that to measure cost-effectiveness of care, we needed to measure total systems cost for the entire episode of illness, including costs before and after the hospital stay.

*Response:* Our policy target adjustment factor, like ProPAC's discretionary adjustment factor, focuses on the percent increase for hospital *inpatient* services only. This focus is appropriate because hospital prospective payments are for inpatient hospital services only. However, we are very concerned about the effect of the prospective payment system on total system costs.

*Comment:* Several commenters suggested that there potentially can be double-counting between our offsets for productivity and ineffectiveness.

*Response:* We were fully aware that significant interactions exist among the components of the policy target adjustment factor (see the June 10, 1985 proposed rule (50 FR 24396)), and took this into account when using the analytical framework to assure no duplicative counting. For inpatient stays, ineffective practice patterns include certain services that are more appropriately provided in lower cost settings (for example, preadmission testing in outpatient facilities, skilled nursing care, and home health agency services), or services that do not give value for money expended. Those persons whose care is shifted totally to a noninpatient setting are not included in this analysis. HCFA used the observed reductions in length of stay during FY 1984 as an indicator of reductions in inpatient hospital ineffective practice patterns. Physicians reduced outputs and we assume that this reduction in outputs, associated with the decline in length of stay, is because they concluded that such outputs did not give value for money expended or could be provided more effectively in a lower cost setting. Under the retrospective cost-based reimbursement system in effect prior to prospective payment system, there was a financial incentive that encouraged longer lengths of stay. The offset factor will not take effect until FY 1986, even though the costs associated with the observed reductions in length of stay occurred in FY 1984. There is no duplication caused by offsets for both productivity and ineffective practice patterns, because the latter are for observed changes in FY 1984 and the productivity offset is for prospective improvements during FYs 1985 and 1986. The policy target adjustment factor for productivity takes into account that productivity increases may occur with a lag after reductions in ineffective pattern outputs associated with the reduction in length of stay in FY 1984. It should be noted that reductions in length of stay do not necessarily translate into increases in productivity when using conventional definitions of productivity (real output per unit of input). Measures of both outputs and inputs are necessary to quantify productivity.

ProPAC agreed with us that the minus one percent allowance for productivity change in the proposed rule represents a reasonable target for FY 1986—even excluding reductions of length of stay observed in FY 1984.

*Comment:* Several commenters raised questions on the most appropriate assumptions for the marginal cost of a day in a hospital relative to average cost. This ratio is needed to make an estimate of the likely cost savings

associated with observed reductions in length of stay.

*Response:* For purposes of determining additional payments for day outlier cases, NCFA currently assumes that the marginal cost of an additional day of stay is equal to 60 percent of the average per diem payment for the applicable DRG, excluding payment for pass-through costs that are not included in the prospective payment rate. (See the January 3, 1984 final rule (49 FR 266) for the discussion of marginal cost assumptions.) The 11 percent reduction in length of stay results in a 6.6 percent reduction in cost per case using this assumption. Our offset factor for the observed length of stay reduction is 2 percent. This allows for the majority of FY 1984 estimated savings to accrue to the hospital industry, and does not take any additional amounts for potential gains in FYs 1985 and 1986. We are not applying an offset of 2 percent until FY 1986, even though the observed reduction in length of stay occurred in FY 1984.

ProPAC points out that studies indicate the marginal cost associated with a patient day ranges from 20 percent to 80 percent, depending on the timeframe. Given this variation in empirical studies, we chose the marginal cost percentage (60 percent) already in place under the prospective payment system. It must also be noted that all overhead associated with capital-related costs and other pass-through items have been eliminated.

As an alternative, we also estimated a 4.4 percent cost savings that would be associated with a 40 percent marginal cost assumption. However, we believe it would be inconsistent to use a higher estimate of marginal cost for outliers and a lower one for the cost effects of reductions in length of stay. We believe the two percent offset used is reasonable and conservative.

(2) *Productivity.* Productivity measures output per unit of input and answers the question as to whether the same output can be accomplished with fewer resources or with a different, less costly, mix of resources. Hospitals often hire industrial engineers and management experts to increase productivity (efficiency) in hospital operations. Productivity improvements result in increases in output prices that are less than the increase in the price of inputs (holding profit margin and the nature of the outputs constant). In competitive industries, consumers benefit from the increases in productivity by paying lower prices. Likewise, under the prospective payment system, increases in productivity should be reflected by lower prices (that is, prospective payment rates) than would otherwise be the case.

Although studies of hospital productivity have been done, and some measures of productivity have been devised for specific applications. Valid productivity indexes comparable to those for other industries are not currently available for the entire hospital industry. Various economy-wide productivity indexes developed by BLS indicate national productivity increases of approximately three percent annually for the last two years (1983 and 1984). However, long-term avarage rates of increase show substantial variation depending upon the time period covered, the industries included, and the productivity measure used (multi-factor productivity or labor productivity).

Given the years of retrospective, cost-based reimbursement, with attendant perverse incentives for productivity, we believe hospitals have the potential for substantial improvements in productivity. We expect that a two percent or more annual increase in productivity would not be unreasonable. Therefore, we are incorporating a 1.0 percent productivity offset (reduction) in the FY 1986 policy target adjustment factor. We believe this is a conservative offset that will allow hospitals to retain more than half of potential productivity gains. We believe sharing the benefits of the prospective payment system in this way provides desirable incentives.

(3) *Cost-effective technologies.* Certain technological changes, especially those related to the adoption of new products (with accompanying labor and nonlabor inputs), increase the operating cost of treating illness but also improve health status commensurately. We believe that the prospective payment rates should recognize new science and technology factors, which are cost-increasing, but also enhance health status. This should provide positive incentives for continued technological and scientific excellence.

The effects of new technologies and scientific advances on operating cost and health status are very complex and are difficult to isolate. Typically, a specific new technology increases cost in some uses and decreases costs in other uses. Concurrently, in some situations, health status is improved while in other situations, it may be unaffected or even worsened using the same technology. Separating out the relative importance of each of these effects for individual technologies and new technologies that are cost-increasing has proven to be elusive from a statistical point of view. Yet, it is important to allow for new technologies and scientific advances. Therefore, we are incorporating a 1.5 percent add-on in the FY 1986 policy target adjustment factor. We expect this add-on to promote, within bounds, the development and use of cost-effective new technologies. The 1.5 percent add-on allows significant growth over time in cost-increasing, health-enhancing new technologies and scientific advances, especially when one considers that all capital costs are currently paid on a cost basis and that this affords an additional allowance for accompanying labor and nonlabor inputs.

(4) *Elimination of ineffective practice patterns.* Just as cost-effective new technologies and scientific advances are expected to increase a hospital's production of cost-effective outputs, and must be encouraged, existing practice patterns that are ineffective in the production of outputs should be discouraged. We believe the implementation of the prospective payment system has substantially increased the incentive for such changes of behavior, by affording hospitals a clear benefit from pursuing them, rather than the disincentive of potential decreases in cost reimbursement. As a prudent buyer, we want to get value for our money. We desire the Medicare Trust Funds and its contributors to share in the benefits accruing from more effective and economical provision of care. Thus, one of our policy targets in setting the level of the Federal rates is to ensure that those rates afford an opportunity for both buyer and provider of services to share the benefits resulting from the elimination of ineffective practice patterns.

Effectiveness compares the objective of improving health status with alternative uses of resources for achieving that objective to determine whether the right, or best available, care is being provided. A hospital can improve the effectiveness with which it delivers health care by—

- Eliminating practices that do not need to be done at all; and
- Ensuring that the only procedures and services furnished in the hospital are those that require a hospital level of care.

We believe that the data on per case costs on which the FY 1984 and FY 1985 standardized amounts were based included a component of unnecessarily high costs reflecting ineffective practice patterns. We believe that hospitals deserve to accrue benefits from these changes, but, nonetheless, we believe it

is reasonable for us to share in them also. Therefore, for these reasons and for the reasons we stated in the addendum to the NPRM (50 FR 24396), we are incorporating a 2.0 percent offset (reduction) in the policy target adjustment factor for FY 1986.

(5) *Composite Policy Target Adjustment.* For FY 1986 and thereafter, we are adjusting the average standardized amounts by a percentage composite policy target adjustment factor, as authorized under section 1886(e)(4) of the Act. For FY 1986, this composite policy target adjustment factor is a composite of the offsets and add-ons for productivity, cost-effective technologies, and cost-ineffective practice patterns, as follows:

| | Percent |
|---|---|
| Productivity | −1.0 |
| Cost-effective technologies | +1.5 |
| Cost-ineffective practice patterns | −2.0 |
| Composite policy target adjustment factor | −1.5 |

f. *Summary.* The combined effect of the forecasted increase in the hospital market basket, the adjustments for Part B costs and FICA taxes, the composite correction factor, and the composite policy target adjustment factor would be a negative FY 1986 prospective payment update factor, as follows:

| | Percent |
|---|---|
| Forecasted market basket increase | +4.27 |
| Part B costs and FICA taxes | +.31 |
| Composite correction factor | −7.5 |
| Composite policy target adjustment factor | −1.5 |
| | −4.42 |

Such a negative update factor would result in a significant decrease in the standardized amounts for FY 1986, compared to those for FY 1985, and a corresponding reduction of anticipated revenue for hospitals subject to the prospective payment system. However, although we have substantial technical and legal justification for issuing FY 1986 standardized amounts that would be lower, on the average, than FY 1985 standardized amounts, we are not establishing lower amounts. In addition, because we believe it is important to protect the prospectivity of this payment system, we are not recouping any excessive payments resulting from the overstated FY 1985 standardized amounts.

The prospective payment system was intended, from its inception, to produce significant changes in the hospital industry. However, if these changes take place too rapidly, disruptions and unintended consequences may result that would adversely affect the industry and Medicare beneficiaries. Neither do we want to encourage changes that would compromise the access to quality inpatient hospital care historically enjoyed by Medicare beneficiaries. Our objective is to set the FY 1986 update factor at a percentage level that takes into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality, in accordance with section 1886(e)(4) of the Act, and we believe that the payment rates should be set no lower than we have proposed in order to assure that this statutory standard is met.

Thus, we are establishing FY 1986 standardized amounts that are set at the same level as those for FY 1985. Because we restandardized the base year costs to reflect the proposed new survey-based wage index, and because the standardized amounts are adjusted to reflect EOMB's revised MSA designations, the amounts set forth in Table 1, in section IV, below, are not identical to those of last year. For the reasons given above, we believe that the resulting payments take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality.

4. *Other Adjustments to the Average Standardized Amounts*—a. *Part B Costs.* Section 1862(a)(14) of the Act prohibits payments for nonphysician services furnished to hospital inpatients unless the services are furnished either directly by the hospital, or by an entity under arrangements made by the hospital under which Medicare's payment to the hospital discharges the beneficiary's liability to pay for the services furnished. In order to adjust urban and rural regional and national standardized amounts per discharge so that they represent costs previously billed under Part B, we increased the amounts by a 0.13 percentage increase (as described in the September 1, 1983 interim final rule (48 FR 39766) and the August 31, 1984 final rule (49 FR 34768)) in both FY 1984 and FY 1985.

We refer the reader to the comment and response discussed in the following section on FICA taxes.

b. *FICA Taxes.* Section 1886(b)(6) of the Act requires that adjustments be made in the base period costs in recognition that certain hospitals were required to enter the Social Security system and begin paying FICA taxes as of January 1, 1984. In FY 1984 and FY 1985, we increased the urban and rural regional and national standardized amounts by 0.18 percent to account for additional costs of payroll taxes for hospitals entering the Social Security system.

*Comment:* One commenter stated that the budget neutrality adjustment in FY 1985 effectively eliminated the adjustments for Part B costs and FICA taxes (estimated at about .31 percent). Therefore, because budget neutrality no longer applies in FY 1986, these adjustments should be restored.

*Response:* We agree with the commenter that although specific add-on adjustments were made to the average standardized amounts for Part B costs and FICA taxes, these adjustments were nullified through the budget neutrality adjustment. In compliance with sections 1862(a)(14) and 1886(b)(6) of the Act, which require that these costs be reflected in the standardized amounts, we are making an upward adjustment for Part B costs and FICA taxes. However, because we decided against reducing the prospective payment rates for FY 1986, these upward adjustments are offset against the amount by which the rates should have decreased. Since the percent magnitude of these adjustments is small, there still is a justified decrease in the rates. Hence, the zero percent increase of the prospective payment rates more than compensates for these adjustments.

c. *Nonphysician anesthetist costs.* In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987.

We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts. (See 49 FR 34794; August 31, 1984). Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.

d. *Outliers.* Section 1886(d)(5)(A) of the Act requires that, in addition to the basic prospective payment rates, payments must be made for discharges involving day outliers and may be made

for cost outliers. Section 1886(d)(2)(E) of the Act correspondingly requires that the standardized amounts be reduced by a proportion that is estimated to reflect outlier payments. Furthermore, section 1886(d)(5)(A)(iv) of the Act directs that outlier payments may not be less than five percent or more than six percent of total payments projected to be made based on the prospective payment rates in any year.

In the September 1, 1983 interim final rule (48 FR 39767), we estimated that outlier payments for FY 1984 would be 6.0 percent of total payments (including both standard prospective payment system payments and outlier payments). We made the maximum estimate permitted under the law in order to ensure that we would provide an adequate margin for outlier payments.

In the final rule published August 31, 1984 (49 FR 34728), we reduced the size of the reserve for outliers from 6.0 percent of total payments, which we had established for FY 1984, to 5.0 percent of total payments for FY 1985, while providing proportionately greater payment for typical cases and avoiding any great risk of general disadvantage to hospitals. We believe that it was in the greater interest of hospitals and the program to eliminate some of the reserve for outliers and correspondingly increase the amount of the standardization rates, thereby providing hospitals with somewhat larger Federal rates for typical cases. We note that this has had the effect of increasing the predictability of total payments for hospitals in that less of the total is attributable to those cases that meet particular qualifications. Therefore, we are continuing to set the size of the outlier reserve at apporoximately the five percent level for FY 1986. As indicated in the previous rules on prospective payments, we will pay for any outlier that meets the criteria in § 412.80, even if aggregate outlier payments result in more than five percent of total payments.

The FY 1985 standardized amounts were reduced by means of the budget neutrality methodology to the level necessary to take into account outlier payments of five percent of total payments based on the Federal rates. (See the August 31, 1984 final rule (49 FR 34795).) We are not making further adjustments to the standardized amounts for FY 1986 or future years, unless we later propose to increase the size of the outlier reserve.

We are revising the day outlier and cost outlier thresholds, using the most recent length of stay and charge data available, to ensure that total estimated outlier payments for FY 1986 are 5.0 percent of total payments. A discharge in FY 1986 will be considered an outlier if the number of days in the stay exceeds the mean length of stay for discharges within the DRG by the lesser of 17 days or 1.94 standard deviations. (For FY 1985, we set the day outlier threshold at the lesser of 22 days or 1.94 standard deviations.) We refer the reader to Table 5 in this addendum for the DRG day outlier thresholds. For FY 1986, a discharge that does not qualify as a day outlier will be considered a high cost outlier if the cost of covered services exceeds the greater of 2.0 times the Federal rate for the DRG, or $13,500. (For FY 1985, we set the cost outlier thresholds at the greater of 2.0 times the Federal rate for the DRG, or $13,000.)

*Comment:* Several commenters suggested that the cost outlier thresholds should remain at the greater of 2.0 times the Federal rate for the DRG or $13,000, or be indexed in proportion to the increase in the prospective payment rates. Because we are not increasing the prospective payment rates in FY 1986, the commenters recommended that the cost outlier threshold criterion should not increase from $13,000 to $13,500.

*Response:* The thresholds for both cost and day outliers are set so as to achieve estimated outlier payments of five percent. Section 1886(d)(5)(A)(iv) of the Act directs that outlier payments may not be less than five percent nor more than six percent of total payments projected to be made based on the prospective payment rates in any year.

In order that the outlier thresholds reflect as closely as possible changing conditions in the hospital industry, we reduced the length-of-stay threshold for day outliers to 17 days in recognition of the continuing decline in hospital lengths of stay. Similarly, as discussed in the NPRM (50 FR 24398), we raised the cost outlier threshold criterion to $13,500 based on the most recent data available (that is, 1984 PATBILL data) that reflect current experience under the prospective payment system.

The cost of discharges is determined by multiplying the billed charges for covered services by .72. This figure represents a national ratio of Medicare inpatient charges and was derived from an analysis of cost and billing data used to establish the DRG relative weights. The .72 figure has remained constant, so that an increase in the charges would lead to increases in costs used to determine cost outlier payments. Therefore, if we did not increase the charge threshold, we would be paying, in the aggregate, too much for cost outliers.

We reiterate that the thresholds are set in order to yield an estimated dollar volume of outlier payments. If we were to retain the cost outlier criterion at $13,000, we would have to change other thresholds in order to achieve the same estimated dollar volume.

*Comment:* Commenters suggested that we are not following the requirements of section 1886(d)(5)(A)(iv) of the Act concerning outlier payments for hospitals. This section provides that payments for outliers may not be less than five percent nor more than six percent of total payments projected to be made based on the prospective payment rates for a given year. Another commenter requested that we publish data to show that outlier payments are in fact between five and six percent of total payments.

*Response:* We believe that these comments may reflect a misunderstanding of the way in which outlier payments are made. In response to the comments received on the September 1, 1983 interim final rule, in the January 3, 1984 final rule we restricted the reduction for outlier payments to the Federal share of the prospective payment rates based on a literal interpretation of sections 1886(d)(2)(E), 1886(d)(3)(B), and 1886(d)(5)(A) of the Act (49 FR 261). Accordingly, we have limited the reduction for outlier payments to the Federal rates, and apply the outlier reduction factor only to the standardized amounts used to compute the Federal portion of the rates. The hospital-specific portion of the prospective payment rate is not reduced for outlier payments.

Because the hospital-specific portion included the cost of outlier cases in each provider's base period, (and in the January 3, 1984 final rule we had determined that the hospital-specific portion was no longer reduced to take account of outliers (49 FR 264)), outlier payment amounts to individual hospitals were reduced in FY 1984 to 25 percent of the otherwise applicable outlier amount. Similarly, in the second year of the transition period (FY 1985), outlier payment amounts were 50 percent of the otherwise applicable outer amount. In the third year of the transition period (FY 1986), outlier payment amounts are 75 percent, and in the fourth year (FY 1987), outlier payment amounts to individual hosptials will be 100 percent of the outlier amount that is computed. Once outlier payments to individual hospitals are based on 100 percent of the computed outlier amount, total system-wide outlier payments will be estimated

to equal five percent of total prospective payments.

As a result of this change in policy, that is, the hospital-specific portion was no longer reduced for outlier payments, which was made in response to comments from the hospital industry, a further calculation is made in determining the appropriate level of outlier payments. Assuming that the threshold level is set at five percent, outlier payments must be multiplied by the appropriate Federal blend percentage for the year involved. For example, during the second year of the transition period (FY 1985), outlier payments should approximate 2.5 percent (5 percent times 50 percent) of total DRG payments.

It is also important to note that, given the data available, forecasts of probable future outlier payments are inexact. Yet, it is these same data that must be used in setting the outlier thresholds. When more recent data become available, they are used in determining whether the outlier thresholds should be revised in order to achieve the percentage of outlier payments within the corridor specified in the law. As with all other aspects of the prospective payment system, we use the most recent data availabe to set the outlier criteria. To the extent that average hospital length of stay remains the same in the future as it is reflected in the most recent data, then we would be paying for outliers at the proper level. If average length of stay continues to decline, we will reflect that in subsequent years' outlier thresholds. It should be noted that, if average length of stay goes up, we will, in effect, overpay the outliers. However, we would not correct this retroactively. Data on actual outlier payments are incomplete at this time and therefore not available.

*Comment:* One commenter suggested that outlier payments are insufficient and should be increased.

*Response:* We refer the reader to the previous comment and response regarding our literal interpretation of the law on the level of outlier payment. In addition, the imprecision of data, also discussed in the previous comment and response, is relevant in this regard. The changes in the outlier thresholds that were set in the August 31, 1984 final rule (49 FR 34768) should also be noted. In that document, we stated that hospitals appeared to be encountering fewer outlier cases than originally anticipated. Therefore, we believe that it was justifiable to increase the outlier thresholds. This had the effect of reducing the offset of the standardized amounts for outlier payments required under section 1886(d)(2)(E) of the Act, and, in effect, increasing the payments (standardized amounts) to all hospitals for typical cases rather than outlier (atypical) cases. We believe that these adjustments are fully within our authority under the law (that is, outlier payments must be within five to six percent of total payments projected to be made under the prospective payment system), and benefitted the large majority of hospitals.

*Comment:* One commenter suggested that HCFA should increase the FY 1986 rates because outlier payments in FY 1985 were lower than expected.

*Response:* Sections 1886(d)(3)(B) and 1886(d)(5)(A)(iv) of the Act require that the standardized amounts be reduced by an amount sufficient to create a fund for outlier payments equal to five to six percent of the total payments estimated to be made during the following year. The outlier payments are then made based on criteria ("trimpoints") established under sections 1886(d)(5)(A)(i) and (ii). Although we properly reduced the standardized amounts in FY 1984 and FY 1985 to create an outlier fund equal to six percent and five percent of total estimated payments respectively, not all of the fund has been disbursed in outlier payments. This low level of payments resulted from the unexpectedly small number of cases that met the criteria established for such payments. Although we believe that the criteria were reasonable at the time they were determined, the subsequent substantial reduction in average hospital length of stay significantly reduced the number of cases qualifying for outlier payments.

We have considered whether this underpayment should be included in the composite correction factor used to establish the rates for FY 1986, but we have concluded that this would not be appropriate. The purpose of the composite correction factor is not to recover overpayments or reimburse for underpayments but to assure that the appropriate percentage change in the rates is applied to the correct base amount. Although fewer outlier payments were made than anticipated, this did not result in lower standardized amounts than would have been the case if outlier payments had been made as predicted. Standardized amounts could not have been increased because of the statutory requirement that they be so reduced as to create at least a five percent outlier fund. Hence, the underpayment does not affect the correctness of the current base and no correction factor would be appropriate.

We have also considered whether the policy target adjustment factor should be increased to account for the lower-than-expected outlier payments in previous years, but we do not believe that such an increase would be appropriate. The policy target adjustment factor is intended to adjust rates for the upcoming year to a level appropriate for the future. It is not appropriately used as a device to collect overpayments or reimburse for underpayments in past years, since such a use would be contrary to the prospective nature of the prospective payment system.

As discussed above, we have made, however, revised the outlier criteria for FY 1986 on the basis of the latest data available. This should reuslt in payment of the full outlier fund in the future.

*Comment:* Many commenters questioned why we pay hospitals only for the number of days indicated by the geometric mean length of stay assigned to each DRG listed in Table 5.

*Response:* There are no requirements under the prospective payment system that Medicare patients, who are classified within a given DRG, be discharged after a specific number of days as indicated by the geometric mean length of stay for that DRG, nor will hospitals be paid for only a certain number of days of care for each discharge within a given DRG. The prospective payment system is not predicated on the belief that all patients should receive the mean or average unit of services or length of stay.

Subject to Medicare eligibility and coverage requirements, payment under the prospective payment system is on a discharge basis without regard to the actual number of days of care furnished to a patient.

The geometric mean length-of-stay figures published in Table 5 of this addendum are geometric means, not the arithmetic means that an individual would usually consider in calculating the average of a distribution. The geometric mean is used as the appropriate statistical measure of central tendency for the purpose of determining day outlier (atypically long length of stay) cases. The geometric mean length-of-stay values, which are usually less than the arithmetic mean values, were used in calculating day outliers because of the particular skewness that is typical of the length-of-stay distribution for each DRG. Because the geometric mean length of stay is typically lower than the arithmetic mean, the day outlier thresholds were lower and less affected by atypically long stays in the data base used to establish outlier thresholds. Those values should not be considered

treatment norms or thresholds for requiring a patient's discharge.

With respect to both geometric and arithmetic mean length-of-stay values, it is important to note that, by virtue of being averages, each measure contains cases on both the high side and the low side. Therefore, it is to be expected that hospitals will encounter cases in which the lengths of stay are longer than the geometric or arithmetic means. Theoretically, it is possible that no case within a particular DRG will fall at exactly the mean length of stay value.

To assist the reader in understanding the difference between arithmetic and geometric mean lengths-of-stay, Table 5 now includes the arithmetic as well as the geometric mean length of stay for each DRG. Note that the addition of the arithmetic mean length-of-stay values is for illustrative and comparative purposes only. The arithmetic values, like the geometric values, do *not* represent limits on the number of hospital days that are paid for under Medicare. The geometric mean lengths of stay will continue to be used in the determination of day outlier cases.

*Comment:* One commenter believes that we should change our outlier policy for hospitals serving as regional referral centers for burn treatment patients. The commenter suggested that these hospitals receive 100 percent of reasonable costs for the outlier portions of patient stays. For the non-outlier portions of stays, the hospital would receive no more than the full DRG payment.

*Response:* The prospective payment system is not designed to recognize all the costs of furnishing services to each Medicare beneficiary. Instead, a predetermined payment amount per discharge is established to provide incentives for hospitals to manage their operations more efficiently. A hospital's payment may be more than its costs for some DRGs, and less than its costs for other DRGs. We believe that aggregate Medicare outlays for inpatient hospital services will equal or exceed the aggregate costs of treating Medicare beneficiaries in efficiently run hospitals.

Section 1886(d)(5)(A) of the Act requires the Secretary to provide an additional payment (day outlier payment) to hospitals for a DRG discharge that exceeds the geometric mean length of stay for discharges within that DRG by the lesser of a fixed number of days or a fixed number of standard deviations. For discharges that do not qualify as day outliers, or for discharges occurring in transferring hospitals, we provide cost outlier payments if the cost of covered services exceeds specified levels.

Under section 1886(d)(5)(A) of the Act, payment for outliers must approximate the marginal cost of care beyond the established cutoff criteria. Consistent with the basic nature of the prospective payment system, we believe that the amount of the additional payments for day outlier cases should be determined in advance, rather than be on a cost-reimbursement basis, as suggested by the commenter. According to health and hospital literature, marginal cost estimates range from 20 to 60 percent of average cost. For purposes of making outlier payments, we are using a 60 percent marginal cost estimate which is at the high end of this range. This 60 percent marginal cost factor is applied to all outlier cases under all DRGs. We do not, however, have sufficient data to estimate marginal costs on a DRG-specific basis or by type of provider.

We recognize that we have general authority under section 1886(d)(5)(C)(iii) of the Act to grant exceptions and adjustments, as we deem appropriate, to the prospective payment amounts. However, we believe that it is generally the better course of action to handle problems that occur under the prospective payments system in a manner that preserves the basis of the system in a fundamentally prospective formula for setting payment for individual DRGs. Establishing individual exceptions and adjustments, to the extent the changes are based on actual costs incurred, tends to undermine the prospective and predictable nature of the system.

We do realize that there may be instances in which the DRG payment may not be reflective of the resources used in treating a patient. We are currently in the process of determining the feasibility as well as the necessity of a severity of illness index. The development of such an index, however, is in the preliminary stage. Still to be determined is whether this index is actually needed, and, if so, what type of index would be most equitable, and at the same time, administratively simple to implement.

### *B. Adjustments for Area Wage Levels and Cost-of-Living*

This section contains an explanation of the application of two types of adjustments to the adjusted standardized amounts that will be made by the intermediaries in determining the prospective payment rates as described in section D. below. For discussion purposes, it is necessary to present the adjusted standardized amounts divided into labor and nonlabor portions. Table 1, as we revised it in this addendum, contains the actual labor-related and nonlabor-related shares that will be used to calculate the prospective payment rates.

#### 1. Adjustment for Area Wage Levels

Section 1886(d)(2)(H) of the Act requires that an adjustment be made to the labor-related portion of the national and regional prospective payment rates to account for area differences in hospital wage levels. This adjustment is made by the intermediaries by multiplying the labor-related portion of the adjusted standardized amount by the appropriate wage index for the area in which the hospital is located. In section III of the preamble to this final rule, we discuss a new wage index based on our own wage survey data. This index is set forth in Tables 4a and 4b of section IV of this addendum.

#### 2. Adjustment for Cost-of-Living in Alaska and Hawaii

Section 1886(d)(5)(C)(iv) of the Act authorizes an adjustment to take into account the unique circumstances of hospitals in Alaska and Hawaii. Higher labor-related costs for these two States were included in the adjustment for area wages above. For FY 1986, the adjustment necessary for nonlabor-related costs for hosptials in Alaska and Hawaii will be made by the intermediaries by multiplying the nonlabor portion of the standardized amounts by the appropriate adjustment factor contained in the table below.

*Table—Cost-of-Living Adjustment Factors, Alaska and Hawaii Hospitals*

| | |
|---|---|
| Alaska—All areas | 1.25 |
| Hawaii: | |
| Oahu | 1.225 |
| Kauai | 1.15 |
| Maui | 1.20 |
| Molokai | 1.20 |
| Lanai | 1.20 |
| Hawaii | 1.125 |

(The above factors are based on data obtained from the U.S. Office of Personnel Management, published in their FPM-581 letter series.)

### *C. DRG Weighting Factors*

As discussed in section II of the preamble to this final rule, we have developed a classification system for all hospital discharges, sorting them into DRGs and have developed weighting factors for each DRG that are intended to reflect the relative resource consumption associated with each DRG.

Table 5 of section IV of this addendum contains the weighting factors that we use for discharges occurring in FY 1986. These factors have been recalibrated as explained in section II of the preamble, and reflect

the changes in the GROUPER program summarized in Table 6.

To indentify certain DRGs more clearly, the titles of the following DRGs are revised as indicated below. These changes are in addition to those discussed in section II.B. of the preamble.

| DRG | Current title | Revised title |
|---|---|---|
| 15 | Transient Ischemic Attack. | Transient Ischemic Attack and Precerebral Occlusions. |
| 39 | Lens Procedures | Lens Procedures with or W/O Vitrectomy. |
| 61 | Myringotomy Age >17. | Myringotomy with Tube Insertion Age >17. |
| 62 | Myringotomy Age 0–17. | Myringotomy with Tube Insertion Age 0–17. |
| 76 | O.R. Proc on the Resp System Except Major Chest With C.C. | Other Respiratory System O.R. Procedures with C.C. |
| 77 | O.R. Proc on the Resp System Except Major Chest W/O C.C. | Other Respiratory System O.R. Procedures W/O C.C. |
| 101 | Other Respiratory Diagnoses Age >69 and/or C.C. | Other Respiratory System Diagnoses Age >69 and/or C.C. |
| 102 | Other Respiratory Diagnoses Age <70 W/O C.C. | Other Respiratory System Diagnoses Age <70 W/O C.C. |
| 108 | Cardiothor Proc, Except Valve and Coronary Bypass, With Pump. | Other Cardiovascular or Thoracis Proc With Pump. |
| 110 | Major Reconstructive Vascular Procedures Age >69 and/or C.C. | Major Reconstructive Vascular Proc W/O Pump Age >69 and/or C.C. |
| 111 | Major Reconstructive Vascular Procedures Age <70 W/O C.C. | Major Reconstructive Vascular Proc W/O Pump Age <70 W/O C.C. |
| 112 | Vascular Procedures Except Major Reconstruction. | Vascular Procedures Except Major Reconstruction W/O Pump. |
| 115 | Permanent Cardiac Pacemaker Implant with AMI or CHF. | Permanent Cardiac Pacemaker Implant with AMI, Heart Failure or Shock. |
| 116 | Permanent Cardiac Pacemaker Implant W/O AMI or CHF. | Permanent Cardiac Pacemaker Implant W/O AMI, Heart Failure or Shock. |
| 120 | Other O.R. Procedures on the Circulatory System. | Other Circulatory System O.R. Procedures. |
| 144 | Other Circulatory Diagnoses with C.C. | Other Circulatory System Diagnoses with C.C. |
| 145 | Other Circulatory Diagnoses W/O C.C. | Other Circulatory System Diagnoses W/O C.C. |
| 157 | Anal Procedures Age >69 and/or C.C. | Anal and Stomal Procedures Age >69 and/or C.C. |
| 158 | Anal Procedures Age <70 W/O C.C. | Anal and Stomal Procedures Age <70 W/O C.C. |
| 168 | Procedures on the Mouth Age >69 and/or C.C. | Mouth Procedures Age >69 and/or C.C. |
| 169 | Procedures on the Mouth Age <70 W/O C.C. | Mouth Procedures Age <70 W/O C.C. |
| 170 | Other Digestive System Procedures Age >69 and/or C.C. | Other Digestive System O.R. Procedures Age >69 and/or C.C. |
| 171 | Other Digestive System Procedures Age <70 W/O C.C. | Other Digestive System O.R. Procedures Age <70 W/O C.C. |
| 209 | Major Joint Procedures. | Major Joint and Limb Reattachment Procedures. |
| 244 | Bone Diseases and Septic Arthropathy Age >69 and/or C.C. | Bone Diseases and Specific Arthropathies Age >69 and/or C.C. |
| 245 | Bone Diseases and Septic Arthropathy Age <70 W/O C.C. | Bone Diseases and Specific Arthropathies Age <70 W/O C.C. |
| 260 | Subtotal Mastectomy for Malignancy Age <70. | Subtotal Mastectomy for Malignancy Age <70 W/O C.C. |
| 263 | Skin Grafts for Skin Ulcer or Cellulitis Age >69 W/O C.C. | Skin Grafts and/or Debridement for Skin Ulcer or Cellulitis Age >69 W/O C.C. |
| 264 | Skin Grafts for Skin Ulcer or Cellulitis Age <70 W/O C.C. | Skin Grafts and/or Debridement for Skin Ulcer or Cellulitis Age <70 W/O C.C. |
| 265 | Skin Grafts Except for Skin Ulcer or Cellulitis with C.C. | Skin Grafts and/or Debridement Except for Skin Ulcer or Cellulitis with C.C. |
| 266 | Skin Grafts Except for Skin Ulcer or Cellulitis W/O C.C. | Skin Grafts and/or Debridement Except for Skin Ulcer or Cellulitis W/O C.C |
| 285 | Amputations for Endocrine, Nutritional + Metabolic Disorders. | Amputations of Lower Limb for Endocrine, Nutritional + Metabolic Disorders. |
| 304 | Kidney, Ureter and Major Bladder Proc For Non-Malignancy Age >69 and/or C.C. | Kidney, Ureter and Major Bladder Proc For Non-Neopl Age >69 and/or C.C. |
| 305 | Kidney, Ureter and Mayor Bladder Proc For Non-Malignancy Age <70 W/O C.C. | Kidney, Ureter, and Major Bladder Proc For Non-Neopl Age <70 W/O C.C |
| 359 | Tubal Interruption for Non-malignancy. | Incisional Tubal Interruption for Non-malignancy. |
| 376 | Postpartum Diagnoses W/O O.R. Procedure. | Postpartum and Postabortion Diagnoses W/O O.R. Procedure |
| 377 | Postpartum Diagnoses with O.R. Procedure.. | Postpartum and Postabortion Diagnoses with O.R. Procedure |
| 381 | Abortion with D+C. | Abortion with D+C, Aspiration Curettage or Hysterotomy. |
| 386 | Extreme Immaturity, Neonate. | Extreme Immaturity or Respiratory Distress Syndrome, Neonate. |
| 401 | Lymphoma or Leukemia with minor O.R. Proc Age >69 and/or C.C. | Lymphoma or Leukemia with other O.R. Proc Age >69 and/or C.C. |
| 402 | Lymphoma or Leukemia with Minor O.R. Procedure Age <70 W/O C.C. | Lymphoma or Leukemia with Other O.R. Procedure Age <70 W/O C.C |
| 408 | Myeloprolif Disord or Poorly Diff Neopl with Minor O.R. Proc. | Myeloprolif Disord or Poorly Diff Neopl with Other O.R. Proc. |
| 449 | Toxic Effects of Drugs Age >69 and/or C.C. | Poisoning and Toxic Effects of Drugs Age >69 and/or C.C. |

| DRG | Current title | Revised title |
|---|---|---|
| 450 .. | Toxic Effects of Drugs Age 18 to 69 W/O C.C. | Poisoning and Toxic Effects of Drugs Age 18 to 69 W/O C.C. |
| 451 .. | Toxic Effects of Drugs Age 0–17. | Poisoning and Toxic Effects of Drugs Age 0 to 17. |

*D. Calculation of Prospective Payment Rates for FY 1986*

FY 1986 represents the third year of the three-year transition period.

*General Formula for Calculation of Prospective Payment Rates for Cost Reporting Periods Beginning on or after October 1, 1985 and Before October 1, 1986*

Prospective Payment Rate=Hospital-Specific Portion+Federal Portion.

1. Hospital-Specific Portion

The hospital-specific portion of the prospective payment rate is based on a hospital's historical cost experience. For the first cost reporting period under prospective payment, a hospital-specific rate was calculated for each hospital, derived generally from the following formula:

$$\frac{\text{(Base year costs per discharge)}}{\text{(1981 case-mix index)}} \times \text{Updating factor} = \text{Hospital specific rate}$$

For the first prospective payment cost reporting period, the hospital-specific portion equaled 75 percent of the hospital-specific rate. For each subsequent transition period cost reporting period, the hospital-specific portion is derived as follows:

Previous Period's Hospital-Specific Rate × Updating Factor × Blending Percentage × DRG Weight

The blending percentage for cost reporting periods beginning in FY 1986 is 25 percent. For a more detailed discussion of the hospital-specific portion, we refer the reader to the September 1, 1983 interim final rule (48 FR 39772).

a. *Updating the Hospital-Specific Rates for FY 1986 Cost Reporting Periods.* We are carrying forward the hospital-specific rates for FY 1985 cost reporting periods without increasing them for FY 1986. For reasons discussed below, the FY 1985 hospital-specific rates were set too high, just as the FY 1985 Federal rates were. If we were to correct the rates prospectively for the full amount of the overstatement, it would result in a reduction of the hospital-specific rates. For the same reasons that we have decided not to reduce the FY 1986 Federal rates, we have decided that it is preferable to carry the rates forward unchanged for the last year of the transition period.

For cost reporting periods beginning in FY 1985, we determined each hospital's hospital-specific rate (before applying the 50 percent blending percentage for the second year of the prospective payment transition period) by applying the applicable compounded target rate percentage, as adjusted for budget neutrality, to the hospital's previous year's hospital-specific rate. The target rate percentages we used incorporated the same overstated market basket percentages as were used in determining the FY 1985 standardized amounts (Federal rates). In addition, each hospital's base-year costs were adjusted to remove the effect of the hospital's 1981 case-mix index, so that the hospital-specific portion, as well as the Federal portion, could be adjusted by a DRG weight in determining payment. As a result, the unanticipated rate of increase in case mix since the implementation of the prospective payment system, discussed above, has also resulted in overstated hospital-specific rates. Note that these are the same factors for which corrections are being applied in determining the revised Federal rates, as discussed in section II.A.3., above.

The requirement of budget neutrality (section 1886(e)(1) of the Act), which is discussed in relation to the Federal rates in section II.A.3 . . above, also governed the level of the target rate percentage increase for hospital-specific rates for cost reporting periods beginning in FY 1985. As we discussed above in regard to the Federal rates, the intent of Congress was that the hospital-specific rates for FY 1986 be updated from *budget neutral* rates for the previous period. However, the target rate percentages for cost reporting periods beginning in FY 1985 were too high to achieve actual budget neutrality. Therefore, we believe that we are required to adjust those hospital-specific rates downward before updating them for cost reporting periods beginning in FY 1986. Similarly, for the same reasons discussed above in relation to the Federal rates, we also believe that the proper exercise of our responsibility under the law would require us to make these adjustments even in the absence of a requirement that the FY 1985 rates be budget neutral.

The reductions to the hospital-specific rates that would be necessary to correct the FY 1985 overstatement fully are as follows:

| | Percent |
|---|---|
| Case-mix | 6.3 |
| Market basket | 1.2 |
| Combined | 7.5 |

b. *Calculation of Hospital-Specific Portion.* For hospital cost reporting periods beginning in FY 1986, the hospital-specific portion of a hospital's payment for a given discharge is calculated by:

Step 1—Multiplying the previous cost reporting period's hospital-specific rate by 25 percent, and

Step 2—Multiplying the amount resulting from Step 1 by the specific DRG weighting factor applicable to the discharge.

The result is the hospital-specific portion of the FY 1986 prospective payment for a given discharge.

c. *New Providers.* Hospitals that had not completed a 12-month cost reporting period under Medicare (either under current or previous ownership) prior to September 30, 1983, or hospitals that meet the criteria in § 412.74(a)(2), are considered new providers for purposes of the prospective payment system. Their prospective payment rates are computed solely on the Federal rates. Thus, new providers are paid a blend of 50 percent of the appropriate Federal regional rate and 50 percent of the Federal national rate for discharges occurring on or after October 1, 1985 and before October 1, 1986.

2. Federal Portion

For cost reporting periods beginning on or after October 1, 1985 and before October 1, 1986, the Federal portion of the hospital's total prospective payment will be 75 percent of the hospital's Federal rate. Beginning with discharges occurring on or after October 1, 1985, the Federal rate is comprised of a blend of the appropriate Federal regional rate (50 percent) and the Federal national rate (50 percent).

*Comment:* Various commenters suggested that, if there is a zero percent increase in the prospective payment rate, the blend of the payment rate should remain at the same levels as in FY 1985; that is, 50 percent of the Federal portion (standardized amounts) and 50 percent of the hospital-specific portion. However, other commenters

recommended that the transition to national prospective payment rates should continue as scheduled.

*Response:* We agree with the latter commenters' recommendation that we should proceed with the transition period as scheduled. The blend of the Federal portion and the hospital-specific portion of the prospective payment rates is mandated by section 1886(d)(1) of the Act. That section provides for a three-year transition period during which a declining portion of the prospective payment rate is based on a hospital's historical cost in a given base year, and a gradually increasing portion is based on a regional Federal rate per discharge in the first year and a blend of a regional and national Federal rate per discharge in the second and third years of the transition period. Section 1886(d)(1) of the Act provides that for discharges occurring on or after October 1, 1983 and before October 1, 1984, the blend was 75 percent hospital-specific portion and 25 percent of the Federal portion; for discharges occurring on or after October 1, 1984 and before October 1, 1985, the blend is 50 percent of the hospital-specific portion and 50 percent of the Federal portion; and for discharges occurring on or after October 1, 1985 and before October 1, 1986, the blend will be 25 percent hospital-specific portion and 75 percent Federal portion. Because the law states exactly what the blend is to be, we must proceed with the third year of the transition period using a blend of 25 percent hospital-specific portion and 75 percent Federal portion. Any change in the blend would require congressional action.

We also point out that hospitals have known since the passage of Pub. L. 98–21 early in 1983 that there would be a transition to national prospective payment rates, and what the transition schedule would be. In our view, hospitals have had sufficient time to accomodate themselves to the transition and to anticipate the implementation of national rates in FY 1987. To delay the transition period at this point would, we believe, have the effect of penalizing efficient hospitals who have taken those steps necessary in anticipation of implementing the national rates in FY 1987.

## III. Revised Target Rate Percentages for Hospitals and Hospital Units Excluded From the Prospective Payment System

### *A. Background*

The inpatient operating costs of hospitals and hospital units excluded from the prospective payment system are subject to rate-of-increase limits established by section 1886(b) of the Act and implemented in § 405.463 of the regulations. Under these limits, an annual target amount (stated as inpatient operating cost per discharge) is set for each hospital, based on the hospital's own cost experience. This target amount is applied as a ceiling on the allowable costs per discharge for the hospital's next cost reporting period.

A hospital that has inpatient operating costs per discharge in excess of its target amount would be paid no more than that target amount. However, a hospital that has inpatient operating costs less than its target amount would be paid its costs plus the lower of (1) 50 percent of the difference between the inpatient operating cost per discharge and the target amount, or (2) five percent of the target amount.

Each hospital's target amount is adjusted annually, before the beginning of its cost reporting period, by an applicable target rate percentage for the 12-month period, prorated based on calendar year target rate percentages. For cost reporting periods beginning in FY 1983 and FY 1984, the applicable target rate percentage was the estimated hospital market basket increase factor plus one percentage point. For cost reporting periods beginning in FY 1985, the applicable target rate percentage is the estimated hospital market basket increase factor plus one-quarter of one percentage point, as prescribed by section 1886(b)(3)(B) of the Act. For cost reporting periods beginning in FY 1986 and thereafter (that is, on or after October 1, 1985), the target rate percentage will be adjusted by an update factor determined by the Secretary under section 1886(e)(4) of the Act, considering the recommendations of ProPAC under section 1886(e)(2) of the Act.

### *B. Revised Target Amounts for Cost Reporting Periods Beginning in FY 1986*

For cost reporting periods beginning in FY 1986, we are carrying forward each hospital's previous year's target amount without increase. This is consistent with the update we are establishing for both Federal rates and hospital-specific rates under the prospective payment system and would comply with the provisions of sections 1886(b)(3)(B) and 1886(e)(4) of the Act, which contemplate a single "percentage change" for all hospitals. In discussing the percentage change, these sections of the Act do not distinguish between hospitals subject to or excluded from the prospective payment system. Thus, we are required to apply the same update factor to both groups of hospitals and to units excluded from the prospective payment system. Given the fact that the target rate is a limit rather than a payment rate, and only affects those hospitals whose costs exceed the limit, it was reasonable for Congress to specify use of the same update factor rather than requiring independent development of different factors for each type of hospital.

In addition, even if we were not required by law to apply the same update factor to hospitals both included in and excluded from prospective payment, we believe it is appropriate to do so. Although certain of the adjustments and factors considered in determining the appropriate update under prospective payment may not apply to excluded hospitals and units, there are other considerations that we believe justify a zero percent increase for FY 1986.

*Comment:* Some commenters stated that it was inappropriate to apply the same prospective payment system update factor to excluded hospitals and units. These commenters disagreed with our determination that the statute requires us to apply the same update factor to both prospective payment hospitals and excluded hospitals and units. One commenter stated that the composite adjustment factor represents a correction of the standardized amounts and is not part of the update factor; therefore, it should not be applied to excluded hospitals and units.

*Response:* Since the rate-of-increase limits were established by Pub. L. 97–248, we have used the same market basket forecast for setting and updating hospitals' target amounts and, effective with the implementation of the prospective payment system, Federal regional and national standardized payment amounts. Moreover, as noted in the June 10, 1985 NPRM (50 FR 24401), in reviewing ProPAC's recommendation that separate market basket weights be used for hospitals and units excluded from the prospective payment system but subject to the rate-of-increase limits, studies to date indicate little difference in market baskets. Therefore, because we have used the same market basket forecasts in the past, and since little evidence supports the hypothesis that the market basket input weights would differ for excluded hospitals, we believe that it is appropriate to use the same market basket forecast of 4.27 percent in updating the target amounts in lieu of developing a separate update factor. Use of the same market basket forecast in the past means that the current target amounts are overstated relative to the most recent market basket forecasts. For this reason, we believe that it is appropriate to apply the same correction

factor of −1.2 percent for market basket forecast error.

While excluded hospitals and units have not had the opportunity to increase their reimbursement through coding changes that increase their case-mix index, it is important to note that an excluded hospital may qualify for an exception to the rate-of-increase limit based on a change in case mix as a result of an addition or discontinuance of services that results in a distortion in the rate of cost increase. (See § 405.463(g).) As to the appropriateness of the policy target adjustment factor, it might at first appear that the incentives to increase productivity and cost-effectiveness are not as strong for hospitals and units still reimbursed on a reasonable cost basis. The determinative factor, however, is that the excluded hospitals have the same opportunities for cost reduction that the prospective payment system hospitals have already exploited and thereby shown to be feasible. Moreover, we believe that the limit on the rate-of-increase in such hospitals' target amounts does, in fact, create the same incentives. This is especially true in view of the fact that a hospital, whose costs are below its target amount, is paid its costs plus the lower of—

- Fifty percent of the difference between its inpatient operating cost per discharge and the target amount; or
- Five percent of the target amount.

For these reasons, we believe it is appropriate to apply the composite policy target adjustment factor of −1.5 percent to the target amounts of hospitals and units subject to the rate-of-increase limits.

We believe that applying the same update factor to *all* hospitals and units is particularly important in view of our goal (and, we believe, Congressional intent) of bringing excluded hospitals and units under the prospective payment system as soon as possible. It is, therefore, appropriate at this time to begin providing excluded hospitals and units with incentives comparable to those experienced by hospitals under the prospective payment system. We expect many excluded hospitals and units will be able to achieve greater efficiency and effectiveness in the delivery of needed services as a response to these limits.

Since the rate-of-increase ceiling is a limit and not a payment rate, excluded hospitals and units that operate efficiently and maintain per case costs below their target amounts would continue to have a margin for increasing costs. In addition, under the provisions of section 1886(b)(4)(A) of the Act and § 405.463(g), a hospital or unit subject to the rate of increase limit may qualify for exceptions to that limit if it demonstrates that a portion of its costs above the limit is attributable to extraordinary circumstances or abrupt changes in patient mix. The availability of such exceptions affords protection for those hospitals that may exceed their target amount ceiling for reasons other than inefficiency.

Beginning with FY 1986, section 1886(e)(3)(A) of the Act instructs the Secretary to "adjust" the standardized amounts in accordance with her final determination under section 1886(e)(4) of the Act, which describes the update factor as the "percentage change". This would include any and all adjustments made to the standardized amounts. The "percentage change" under section 1886(e)(4) replaces the "percentage increase" under section 1886(b)(3)(B) of the Act, which applies to both prospective payment system hospitals and excluded hospitals and units. The law refers to the "percentage change" as a single factor and does not contemplate the application of separate factors for prospective payment system hospitals and excluded hospitals and units. Therefore, we are required to apply the same "percentage change" to both the prospective payment standardized amounts and the target rate of increase limit for excluded hospitals and units.

## IV. Tables

This section contains the tables referred to throughout the preamble to this final rule and in this addendum. For Tables 2, 3a, and 3b, refer to the September 1, 1983 interim final rule (48 FR 39845).

TABLE 1.—ADJUSTED STANDARDIZED AMOUNTS, LABOR/NONLABOR

| Region | Urban | | Rural | |
|---|---|---|---|---|
| | Labor related | Nonlabor related | Labor related | Nonlabor related |
| 1. New England (CT, ME, MA, NH, RI, VT) | 2361.23 | 668.56 | 2132.35 | 507.22 |
| 2. Middle Atlantic (PA, NJ, NY) | 2217.30 | 660.71 | 2166.25 | 514.40 |
| 3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV) | 2354.76 | 612.14 | 1987.52 | 427.03 |
| 4. East North Central (IL, IN, MI, OH, WI) | 2435.73 | 712.68 | 1971.73 | 478.79 |
| 5. East South Central (AL, KY, MS, TN) | 2235.04 | 544.16 | 1977.12 | 399.85 |
| 6. West North Central (IA, KS, MN, MO, NB, ND, SD) | 2260.57 | 633.09 | 1836.34 | 410.83 |
| 7. West South Central (AR, LA, OK, TX) | 2307.62 | 599.67 | 1853.44 | 398.47 |
| 8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY) | 2203.70 | 634.49 | 1819.46 | 445.73 |
| 9. Pacific (AK, CA, HI, OR, WA) | 2208.57 | 745.34 | 1828.74 | 521.49 |
| 10. National | 2308.29 | 664.16 | 1920.46 | 437.97 |

TABLE 4a.—WAGE INDEX FOR URBAN AREAS

| Urban area (constituent counties or county equivalents) | Wage index |
|---|---|
| Abilene TX | .8937 |
| Taylor, TX | |
| Akron, OH | 1.1000 |
| Portage, OH | |
| Summit, OH | |
| Albany, GA | .8124 |
| Dougherty, GA | |
| Lee, GA | |
| Albany-Schenectady-Troy, NY | .9278 |
| Albany, NY | |
| Greene, NY | |
| Montgomery, NY | |
| Rensselaer, NY | |
| Saratoga, NY | |
| Schenectady, NY | |
| Albuquerque, NM | 1.0998 |
| Bernalillo, NM | |
| Alexandria, LA | .9102 |
| Rapides, LA | |
| Allentown-Bethlehem, PA-NJ | 1.0379 |
| Warren, NJ | |
| Carbon, PA | |
| Lehigh, PA | |
| Northampton, PA | |
| Altoona, PA | .9950 |
| Blair, PA | |
| Amarillo, TX | .9526 |
| Potter, TX | |
| Randall, TX | |
| Anaheim-Santa Ana, CA | 1.2528 |
| Orange, CA | |
| Anchorage, AK | 1.5735 |

## TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

| Urban area (constituent counties or county equivalents) | Wage index |
|---|---|
| Anchorage, AK | |
| Anderson, IN | .9185 |
| Madison, IN | |
| Anderson, SC | .8309 |
| Anderson, SC | |
| Ann Arbor, MI | 1.2515 |
| Washtenaw, MI | |
| Anniston, AL | .8457 |
| Calhoun, AL | |
| Appleton-Oshkosh-Neenah, WI | 1.0671 |
| Calumet, WI | |
| Outagamie, WI | |
| Winnebago, WI | |
| Asheville, NC | .8780 |
| Buncombe, NC | |
| Athens, GA | .8120 |
| Clarke, GA | |
| Jackson, GA | |
| Madison, GA | |
| Oconee, GA | |
| Atlanta, GA | .9594 |
| Barrow, GA | |
| Butts, GA | |
| Cherokee, GA | |
| Clayton, GA | |
| Cobb, GA | |
| Coweta, GA | |
| De Kalb, GA | |
| Douglas, GA | |
| Fayette, GA | |
| Forsyth, GA | |
| Fulton, GA | |
| Gwinnett, GA | |
| Henry, GA | |
| Newton, GA | |
| Paulding, GA | |
| Rockdale, GA | |
| Spalding, GA | |
| Walton, GA | |
| Atlantic City, NJ | 1.0489 |
| Atlantic, NJ | |
| Cape May, NJ | |
| Augusta, GA–SC | .9533 |
| Columbia, GA | |
| McDuffie, GA | |
| Richmond, GA | |
| Aiken, SC | |
| Aurora-Elgin, IL | 1.0936 |
| Kane, IL | |
| Kendall, IL | |
| Austin, TX | 1.1096 |
| Hays, TX | |
| Travis, TX | |
| Williamson, TX | |
| Bakersfield, CA | 1.1972 |
| Kern, CA | |
| Baltimore, MD | 1.1069 |
| Anne Arundel, MD | |
| Baltimore, MD | |
| Baltimore City, MD | |
| Carroll, MD | |
| Harford, MD | |
| Howard, MD | |
| Queen Annes, MD | |
| Bangor, ME | .9135 |
| Penobscot, ME | |
| Baton Rouge, LA | .9754 |
| Ascension, LA | |
| East Baton Rouge, LA | |
| Livingston, LA | |
| West Baton Rouge, LA | |
| Battle Creek, MI | 1.0228 |
| Calhoun, MI | |
| Beaumont-Port Arthur, TX | 1.0009 |
| Hardin, TX | |
| Jefferson, TX | |
| Orange, TX | |
| Beaver County, PA | 1.0840 |
| Beaver, PA | |
| Bellingham, WA | 1.1388 |
| Whatcom, WA | |
| Benton Harbor, MI | .8847 |
| Berrien, MI | |
| Bergen-Passaic, NJ | 1.0670 |
| Bergen, NJ | |
| Passaic, NJ | |
| Billings, MT | 1.0152 |
| Yellowstone, MT | |
| Biloxi-Gulfport, MS | .8428 |
| Hancock, MS | |
| Harrison, MS | |
| Binghamton, NY | .9489 |
| Broome, NY | |
| Tioga, NY | |
| Birmingham, AL | .9594 |
| Blount, AL | |
| Jefferson, AL | |
| Saint Clair, AL | |
| Shelby, AL | |
| Walker, AL | |
| Bismarck, ND | .9871 |
| Burleigh, ND | |
| Morton, ND | |
| Bloomington, IN | .9828 |
| Monroe, IN | |
| Bloomington-Normal, IL | .9773 |
| McLean, IL | |
| Boise City, ID | 1.0508 |
| Ada, ID | |
| Boston-Lawrence-Salem-Lowell-Brockton, MA | 1.1485 |
| Essex, MA | |
| Middlesex, MA | |
| Norfolk, MA | |
| Plymouth, MA | |
| Suffolk, MA | |
| Boulder-Longmont, CO | 1.1244 |
| Boulder, CO | |
| Bradenton, FL | .9129 |
| Manatee, FL | |
| Brazoria, TX | .8679 |
| Brazoria, TX | |
| Bremerton, WA | .9742 |
| Kitsap, WA | |
| Bridgeport-Stamford-Norwalk-Danbury, CT | 1.1760 |
| Fairfield, CT | |
| Brownsville-Harlingen, TX | .8912 |
| Cameron,TX | |
| Bryan-College Station, TX | .9500 |
| Brazos, TX | |
| Buffalo, NY | 1.0474 |
| Erie, NY | |
| Burlington, NC | .7868 |
| Alamance, NC | |
| Burlington, VT | 1.0058 |
| Chittenden, VT | |
| Grand Isle, VT | |
| Canton, OH | 1.0007 |
| Carroll, OH | |
| Stark, OH | |
| Casper, WY | 1.0984 |
| Natrona, WY | |
| Cedar Rapids, IA | 1.0101 |
| Linn, IA | |
| Champaign-Urbana-Rantoul, IL | .9893 |
| Champaign, IL | |
| Charleston, SC | .8847 |
| Berkeley, SC | |
| Charleston, SC | |
| Dorchester, SC | |
| Charleston, WV | 1.0406 |
| Kanawha, WV | |
| Putnam, WV | |
| Charlotte-Gastonia-Rock Hill, NC-SC | .8926 |
| Cabarrus, NC | |
| Gaston, NC | |
| Lincoln, NC | |
| Mecklenburg, NC | |
| Rowan, NC | |
| Union, NC | |
| York, SC | |
| Charlottesville, VA | .9278 |
| Albermarle, VA | |
| Charlottesville City, VA | |
| Fluvanna, VA | |
| Greene, VA | |
| Chattanooga, TN-GA | .9968 |
| Catoosa, GA | |
| Dade, GA | |
| Walker, GA | |
| Hamilton, TN | |
| Marion, TN | |
| Sequatchie, TN | |
| Cheyenne, WY | .9631 |
| Laramie, WY | |
| Chicago, IL | 1.2299 |
| Cook, IL | |
| Du Page, IL | |
| McHenry, IL | |
| Chico, CA | 1.2373 |
| Butte, CA | |
| Cincinnati, OH-KY-IN | 1.0970 |
| Dearborn, IN | |
| Boone, KY | |
| Campbell, KY | |
| Kenton, KY | |
| Clermont, OH | |
| Hamilton, OH | |
| Warren, OH | |
| Clarksville-Hopkinsville, TN-KY | .8124 |
| Christian, KY | |
| Montgomery, TN | |
| Cleveland, OH | 1.1481 |
| Cuyahoga, OH | |
| Geauga, OH | |
| Lake, OH | |
| Medina, OH | |
| Colorado Springs, CO | 1.0363 |
| El Paso, CO | |
| Columbia, MO | 1.0942 |
| Boone, MO | |
| Columbia, SC | .9102 |
| Lexington, SC | |

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

| Urban area (constituent counties or county equivalents) | Wage index |
|---|---|
| Richland, SC | |
| Columbus, GA-AL | .7872 |
| Russell, AL | |
| Chattanoochee, GA | |
| Muscogee, GA | |
| Columbus, OH | .9614 |
| Delaware, OH | |
| Fairfield, OH | |
| Franklin, OH | |
| Licking, OH | |
| Madison, OH | |
| Pickaway, OH | |
| Union, OH | |
| Corpus Christi, TX | .9827 |
| Nueces, TX | |
| San Patricio, TX | |
| Cumberland, MD-WV | .8931 |
| Allegeny, MD | |
| Mineral, WV | |
| Dallas, TX | 1.0656 |
| Collin, TX | |
| Dallas, TX | |
| Denton, TX | |
| Ellis, TX | |
| Kaufman, TX | |
| Rockwall, TX | |
| Danville, VA | .8028 |
| Danville City, VA | |
| Pittsylvania, VA | |
| Davenport-Rock Island-Moline, IA-IL | 1.0583 |
| Scott, IA | |
| Henry, IL | |
| Rock Island, IL | |
| Dayton-Springfield, OH | 1.0860 |
| Clark, OH | |
| Greene, OH | |
| Miami, OH | |
| Montgomery, OH | |
| Daytona Beach, FL | .9073 |
| Volusia, FL | |
| Decatur, IL | .9523 |
| Macon, IL | |
| Denver, CO | 1.2772 |
| Adams, CO | |
| Arapahoe, CO | |
| Denver, CO | |
| Douglas, CO | |
| Jefferson, CO | |
| Des Moines, IA | 1.0480 |
| Dallas, IA | |
| Polk, IA | |
| Warren, IA | |
| Detroit, MI | 1.1640 |
| Lapeer, MI | |
| Livingston, MI | |
| Macomb, MI | |
| Monroe, MI | |
| Oakland, MI | |
| Saint Clair, MI | |
| Wayne, MI | |
| Dothan, AL | .8396 |
| Dale, AL | |
| Houston, AL | |
| Dubuque, IA | 1.0514 |
| Dubuque, IA | |
| Duluth, MN-WI | .9858 |
| St. Louis, MN | |
| Douglas, WI | |

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

| Urban area (constituent counties or county equivalents) | Wage index |
|---|---|
| Eau Claire, WI | .9429 |
| Chippewa, WI | |
| Eau Claire, WI | |
| El Paso, TX | .9369 |
| El Paso, TX | |
| Elkhart-Goshen, IN | .9581 |
| Elkhart, IN | |
| Elmira, NY | .9670 |
| Chemung, NY | |
| Enid, OK | .9557 |
| Garfield, OK | |
| Erie, PA | .9919 |
| Erie, PA | |
| Eugene-Springfield, OR | 1.1082 |
| Lane, OR | |
| Evansville, IN-KY | 1.0143 |
| Posey, IN | |
| Vanderburgh, IN | |
| Warrick, IN | |
| Henderson, KY | |
| Fargo-Moorhead, ND-MN | 1.0567 |
| Clay, MN | |
| Cass, ND | |
| Fayetteville, NC | .8270 |
| Cumberland, NC | |
| Fayetteville-Springdale, AR | .8020 |
| Washington, AR | |
| FLint, MI | 1.2016 |
| Genesee, MI | |
| Florence, AL | .7832 |
| Colbert, AL | |
| Lauderdale, AL | |
| FLorence, SC | .7631 |
| FLorence, SC | |
| Fort Collins-Loveland, CO | 1.0768 |
| Larimor, CO | |
| Fort Lauderdale-Hollywood-Pompano Beach, FL | 1.1168 |
| Broward, FL | |
| Fort Myers-Cape Coral, FL | .9464 |
| Lee, FL | |
| Fort Pierce, FL | 1.0141 |
| Martin, FL | |
| St. Lucie, FL | |
| Fort Smith, AR-OK | .9176 |
| Crawford, AR | |
| Sebastian, AR | |
| Sequoyah, OK | |
| Fort Walton Beach, FL | .8688 |
| Okaloosa, FL | |
| Fort Wayne, IN | .9499 |
| Allen, IN | |
| De Kalb, IN | |
| Whitley, IN | |
| Fort Worth-Arlington, TX | .9926 |
| Johnson, TX | |
| Parker, TX | |
| Tarrant, TX | |
| Fresno, CA | 1.1407 |
| Fresno, CA | |
| Gadsden, AL | .8713 |
| Etowah, AL | |
| Gainesville, FL | .9572 |
| Alachua, FL | |
| Bradford, FL | |
| Galveston-Texas City, TX | 1.1329 |
| Galveston, TX | |
| Gary-Hammond, IN | 1.0899 |

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

| Urban area (constituent counties or county equivalents) | Wage index |
|---|---|
| Lake, IN | |
| Porter, IN | |
| Glens Falls, NY | .9538 |
| Warren, NY | |
| Washington, NY | |
| Grand Forks, ND | .9800 |
| Grand Forks, ND | |
| Grand Rapids, MI | 1.0586 |
| Kent, MI | |
| Ottawa, MI | |
| Great Falls, MT | 1.0644 |
| Cascade, MT | |
| Greeley, CO | 1.0685 |
| Weld, CO | |
| Green Bay, WI | 1.0252 |
| Brown, WI | |
| Greensboro-Winston-Salem-High Point, NC | .9320 |
| Davidson, NC | |
| Davie, NC | |
| Forsyth, NC | |
| Guilford, NC | |
| Randolph, NC | |
| Stokes, NC | |
| Yadkin, NC | |
| Greenville-Spartanburg, SC | .9064 |
| Greenville, SC | |
| Pickens, SC | |
| Spartanburg, SC | |
| Hagerstown, MD | .9516 |
| Washington, MD | |
| Hamilton-Middletown, OH | 1.0140 |
| Butler, OH | |
| Harrisburg-Lebanon-Carlisle, PA | .9796 |
| Cumberland, PA | |
| Dauphin, PA | |
| Lebanon, PA | |
| Perry, PA | |
| Hartford-New Middletown-Britain-Bristol, CT | 1.1379 |
| Hartford, CT | |
| Litchfield, CT | |
| Middlesex, CT | |
| Tolland, CT | |
| Hickory, NC | .8917 |
| Alexander, NC | |
| Burke, NC | |
| Catawba, NC | |
| Honolulu, HI | 1.1935 |
| Honolulu, HI | |
| Houma-Thibodaux, LA | .9162 |
| Lafourche, LA | |
| Terrebonne, LA | |
| Houston, TX | 1.0591 |
| Fort Bend, TX | |
| Harris, TX | |
| Liberty, TX | |
| Montgomery, TX | |
| Waller, TX | |
| Huntington-Ashland, WV-KY-OH | .9441 |
| Boyd, KY | |
| Carter, KY | |
| Greenup, KY | |
| Lawrence, OH | |
| Cabell, WV | |
| Wayne, WV | |
| Huntsville, AL | .8599 |
| Madison, AL | |

## TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

| Urban area (constituent counties or county equivalents) | Wage index |
|---|---|
| Indianapolis, IN | 1.0517 |
| Boone, IN | |
| Hamilton, IN | |
| Hancock, IN | |
| Hendricks, IN | |
| Johnson, IN | |
| Marion, IN | |
| Morgan, IN | |
| Shelby, IN | |
| Iowa City, IA | 1.2990 |
| Johnson, IA | |
| Jackson, MI | 1.0132 |
| Jackson, MI | |
| Jackson, MS | .9279 |
| Hinds, MS | |
| Madison, MS | |
| Rankin, MS | |
| Jackson, TN | .7859 |
| Madison, TN | |
| Jacksonville, FL | .9412 |
| Clay, FL | |
| Duval, FL | |
| Nassau, FL | |
| St. Johns, FL | |
| Jacksonville, NC | .7908 |
| Onslow, NC | |
| Janesville-Beloit, WI | .9353 |
| Rock, WI | |
| Jersey City, NJ | 1.0529 |
| Hudson, NJ | |
| Johnson City-Kingsport-Bristol, TN-VA | .8555 |
| Carter, TN | |
| Hawkins, TN | |
| Sullivan, TN | |
| Unicoi, TN | |
| Washington, TN | |
| Bristol City, VA | |
| Scott, VA | |
| Washington, VA | |
| Johnstown, PA | .9457 |
| Cambria, PA | |
| Somerset, PA | |
| Joliet, IL | 1.1172 |
| Grundy, IL | |
| Will, IL | |
| Joplin, MO | .9136 |
| Jasper, MO | |
| Newton, MO | |
| Kalamazoo, MI | 1.2252 |
| Kalamazoo, MI | |
| Kankakee, IL | .9441 |
| Kankakee, IL | |
| Kansas City, KS-MO | 1.0583 |
| Johnson, KS | |
| Leavenworth, KS | |
| Miami, KS | |
| Wyandotte, KS | |
| Cass, MO | |
| Clay, MO | |
| Jackson, MO | |
| Lafayette, MO | |
| Platte, MO | |
| Ray, MO | |
| Kenosha, WI | 1.0796 |
| Kenosha, WI | |
| Killeen-Temple, TX | .8785 |
| Bell, TX | |
| Coryell, TX | |
| Knoxville, TN | .8931 |
| Anderson, TN | |
| Blount, TN | |
| Grainger, TN | |
| Jefferson, TN | |
| Knox, TN | |
| Sevier, TN | |
| Union, TN | |
| Kokomo, IN | .9799 |
| Howard, IN | |
| Tipton, IN | |
| LaCrosse, WI | 1.0093 |
| LaCrosse, WI | |
| Lafayette, LA | 1.0041 |
| Lafayette, LA | |
| St. Martin, LA | |
| Lafayette, IN | .9097 |
| Tippecanoe, IN | |
| Laake Charles, LA | .9964 |
| Calcasieu, LA | |
| Lake County, IL | 1.1552 |
| Lake, IL | |
| Lakeland-Winter Haven, FL | .8787 |
| Polk, FL | |
| Lancaster, PA | 1.0320 |
| Lancaster, PA | |
| Lansing-East Lansing, MI | 1.0692 |
| Clinton, MI | |
| Eaton, MI | |
| Ingham, MI | |
| Laredo, TX | .8104 |
| Webb, TX | |
| Las Cruces, NM | .8703 |
| Dona Ana, NM | |
| Las Vegas, NV | 1.1173 |
| Clark, NV | |
| Lawrence, KS | 1.0106 |
| Douglas, KS | |
| Lawton, OK | .9400 |
| Comanche, OK | |
| Lewiston-Auburn, ME | .9357 |
| Androscoggin, ME | |
| Lexington-Fayette, KY | .9802 |
| Bourbon, KY | |
| Clark, KY | |
| Fayette, KY | |
| Jessamine, KY | |
| Scott, KY | |
| Woodford, KY | |
| Lima, OH | .9795 |
| Allen, OH | |
| Auglaize, OH | |
| Lincoln, NE | .9640 |
| Lancaster, NE | |
| Little Rock-North Little Rock, AR | 1.1055 |
| Faulker, AR | |
| Lonoke, AR | |
| Pulaski, AR | |
| Saline, AR | |
| Longview-Marshall, TX | .8349 |
| Gregg, TX | |
| Harrison, TX | |
| Lorain-Elyria, OH | 1.0205 |
| Lorain, OH | |
| Los Angeles-Long Beach, CA | 1.3193 |
| Los Angeles, CA | |
| Louisville, KY-IN | 1.0009 |
| Clark, IN | |
| Floyd, IN | |
| Harrison, IN | |
| Bullitt, KY | |
| Jefferson, KY | |
| Oldham, KY | |
| Shelby, KY | |
| Lubbock,TX | 1.0055 |
| Lubbock, TX | |
| Lynchburg, VA | .8198 |
| Amherst, VA | |
| Campbell, VA | |
| Lynchburg City, VA | |
| Macon-Warner Robins, GA | .9257 |
| Bibb, GA | |
| Houston, GA | |
| Jones, GA | |
| Peach, GA | |
| Madison, WI | 1.0823 |
| Dane, WI | |
| Manchester-Nashua, NH | .9508 |
| Hillsboro, NH | |
| Merrimack, NH | |
| Mansfield, OH | .9847 |
| Richland, OH | |
| McAllen-Edinburg-Mission, TX | .8046 |
| Hidalgo, TX | |
| Medford, OR | 1.0281 |
| Jackson, OR | |
| Melbourne-Titusville, FL | .9310 |
| Brevard, FL | |
| Memphis, TN-AR-MS | 1.0418 |
| Crittenden, AR | |
| De Soto, MS | |
| Shelby, TN | |
| Tipton, TN | |
| Miami-Hialeah, FL | 1.0625 |
| Dade, FL | |
| Middlesex-Somerset-Hunterdon, NJ | 1.0274 |
| Hunterdon, NJ | |
| Middlesex, NJ | |
| Somerset, NJ | |
| Midland, TX | 1.1223 |
| Midland, TX | |
| Milwaukee, WI | 1.1329 |
| Milwaukee, WI | |
| Ozaukee, WI | |
| Washington, WI | |
| Waukesha, WI | |
| Minneapolis-St. Paul, MN-WI | 1.1687 |
| Anoka, MN | |
| Carver, MN | |
| Chisago, MN | |
| Dakota, MN | |
| Hennepin, MN | |
| Isanti, MN | |
| Ramsey, MN | |
| Scott, MN | |
| Washington, MN | |
| Wright, MN | |
| St. Croix, WI | |
| Mobile, AL | .8863 |
| Baldwin, AL | |
| Mobile, AL | |
| Modesto, CA | 1.2015 |
| Stanislaus, CA | |
| Monmouth-Ocean, NJ | .9853 |

## TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

| Urban area (constituent counties or county equivalents) | Wage index |
|---|---|
| Monmouth, NJ | |
| Ocean, NJ | |
| Monroe, LA | .9275 |
| Ouachita, LA | |
| Montgomery, AL | .8812 |
| Autauga, AL | |
| Elmore, AL | |
| Montgomery, AL | |
| Muncie, IN | .9993 |
| Delaware, IN | |
| Muskegon, MI | .9640 |
| Muskegon, MI | |
| Naples, FL | 1.0373 |
| Collier, FL | |
| Nashville, TN | .9846 |
| Cheatham, TN | |
| Davidson, TN | |
| Dickson, TN | |
| Robertson, TN | |
| Ruthford, TN | |
| Sumner, TN | |
| Williamson, TN | |
| Wilson, TN | |
| Nassau-Suffolk, NY | 1.3278 |
| Nassau, NY | |
| Suffolk, NY | |
| New Bedford-Fall River-Attleboro, MA | .9725 |
| Bristol, MA | |
| New Haven-West Haven-Waterbury-Meriden, CT | 1.1194 |
| New Haven, CT | |
| New London-Norwich, CT | 1.1023 |
| New London, CT | |
| New Orleans, LA | .9277 |
| Jefferson, LA | |
| Orleans, LA | |
| St. Bernard, LA | |
| St. Charles, LA | |
| St. John The Baptist, LA | |
| St. Tammany, LA | |
| New York, NY | 1.3710 |
| Bronx, NY | |
| Kings, NY | |
| New York City, NY | |
| Putnam, NY | |
| Queens, NY | |
| Richmond, NY | |
| Rockland, NY | |
| Westchester, NY | |
| Newark, NJ | 1.1321 |
| Essex, NJ | |
| Morris, NJ | |
| Sussex, NJ | |
| Union, NJ | |
| Niagara Falls, NY | .8894 |
| Niagara, NY | |
| Norfolk-Virginia Beach-Newport News, VA | .9622 |
| Chesapeake City, VA | |
| Gloucester, VA | |
| Hampton City, VA | |
| James City Co., VA | |
| Newport News City, VA | |
| Norfolk City, VA | |
| Poquoson, VA | |
| Portsmouth City, VA | |
| Suffolk City, VA | |
| Virginia Beach City, VA | |
| Williamsburg City, VA | |
| York, VA | |
| Oakland, CA | 1.4793 |
| Alameda, CA | |
| Contra Costa, CA | |
| Ocala, FL | .8672 |
| Marion, FL | |
| Odessa, TX | .9550 |
| Ector, TX | |
| Oklahoma City, OK | 1.0851 |
| Canadian, OK | |
| Cleveland, OK | |
| Logan, OK | |
| McClain, OK | |
| Oklahoma, OK | |
| Pottawatomie, OK | |
| Olympia, WA | 1.0709 |
| Thurston, WA | |
| Omaha, NE-IA | 1.0433 |
| Pottawattamie, IA | |
| Douglas, NE | |
| Sarpy, NE | |
| Washington, NE | |
| Orange County, NY | .9232 |
| Orange, NY | |
| Orlando, FL | 1.0115 |
| Orange, FL | |
| Osceola, FL | |
| Seminole, FL | |
| Owensboro, KY | .8184 |
| Daviess, KY | |
| Oxnard-Ventura, CA | 1.2807 |
| Ventura, CA | |
| Panama City, FL | .8293 |
| Bay, FL | |
| Parkersburg-Marietta, WV-OH | .9055 |
| Washington, OH | |
| Wood, WV | |
| Pascagoula, MS | .9608 |
| Jackson, MS | |
| Pensacola, FL | .8679 |
| Escambia, FL | |
| Santa Rosa, FL | |
| Peoria, IL | 1.0508 |
| Peoria, IL | |
| Tazewell, IL | |
| Woodford, IL | |
| Philadelphia, PA-NJ | 1.1789 |
| Burlington, NJ | |
| Camden, NJ | |
| Gloucester, NJ | |
| Bucks, PA | |
| Chester, PA | |
| Delaware, PA | |
| Montgomery, PA | |
| Philadelphia, PA | |
| Phoenix, AZ | 1.0723 |
| Maricopa, AZ | |
| Pine Bluff, AR | .7952 |
| Jefferson, AR | |
| Pittsburgh, PA | 1.0932 |
| Allegheny, PA | |
| Fayette, PA | |
| Washington, PA | |
| Westmoreland, PA | |
| Pittsfield, MA | 1.0172 |
| Berkshire, MA | |
| Portland, ME | .9808 |
| Cumberland, ME | |
| Sagadahoc, ME | |
| York, ME | |
| Portland, OR | 1.1987 |
| Clackamas, OR | |
| Multnomah, OR | |
| Washington, OR | |
| Yamhill, OR | |
| Portsmouth-Dover-Rochester, NH | .9305 |
| Rockingham, NH | |
| Strafford, NH | |
| Poughkeepsie, NY | 1.0174 |
| Dutchess, NY | |
| Providence-Pawtucket-Woonsocket, RI | 1.0426 |
| Bristol, RI | |
| Kent, RI | |
| Newport, RI | |
| Providence, RI | |
| Statewide, RI | |
| Washington, RI | |
| Provo-Orem, UT | .9786 |
| Utah, UT | |
| Pueblo, CO | 1.1129 |
| Pueblo, CO | |
| Racine, WI | .9930 |
| Racine, WI | |
| Raleigh-Durham, NC | .9650 |
| Durham, NC | |
| Franklin, NC | |
| Orange, NC | |
| Wake, NC | |
| Rapid City, SD | .9554 |
| Pennington, SD | |
| Reading, PA | 1.0174 |
| Berks, PA | |
| Redding, CA | 1.2306 |
| Shasta, CA | |
| Reno, NV | 1.1753 |
| Washoe, NV | |
| Richland-Kennewick, WA | 1.0182 |
| Benton, WA | |
| Franklin, WA | |
| Richmond-Petersburg, VA | .9529 |
| Charles City Co., VA | |
| Chesterfield, VA | |
| Colonial Heights City, VA | |
| Dinwiddie, VA | |
| Goochland, VA | |
| Hanover, VA | |
| Henrico, VA | |
| Hopewell City, VA | |
| New Kent, VA | |
| Petersburg City, VA | |
| Powhatan, VA | |
| Prince George, VA | |
| Richmond City, VA | |
| Riverside-San Bernardino, CA | 1.2426 |
| Riverside, CA | |
| San Bernardino, CA | |
| Roanoke, VA | .8932 |
| Botetourt, VA | |
| Roanoke, VA | |
| Roanoke City, VA | |
| Salem City, VA | |
| Rochester, MN | 1.0210 |
| Olmsted, MN | |

TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

| Urban area (constituent counties or county equivalents) | Wage index |
|---|---|
| Rochester, NY | 1.0152 |
| Livingston, NY | |
| Monroe, NY | |
| Ontario, NY | |
| Orleans, NY | |
| Wayne, NY | |
| Rockford, IL | 1.1272 |
| Boone, IL | |
| Winnebago, IL | |
| Sacramento, CA | 1.2875 |
| Eldorado, CA | |
| Placer, CA | |
| Sacramento, CA | |
| Yolo, CA | |
| Saginaw-Bay City-Midland, MI | 1.0990 |
| Bay, MI | |
| Midland, MI | |
| Saginaw, MI | |
| St. Cloud, MN | .9945 |
| Benton, MN | |
| Sherburne, MN | |
| Stearns, MN | |
| St. Joseph, MO | .9418 |
| Buchanan, MO | |
| St. Louis, MO-IL | 1.0748 |
| Clinton, IL | |
| Jersey, IL | |
| Madison, IL | |
| Monroe, IL | |
| St. Clair, IL | |
| Franklin, MO | |
| Jefferson, MO | |
| St. Charles, MO | |
| St. Louis, MO | |
| St. Louis City, MO | |
| Salem, OR | 1.0892 |
| Marion, OR | |
| Polk, OR | |
| Salinas-Seaside-Monterey, CA | 1.2480 |
| Monterey, CA | |
| Salt Lake City-Ogden, UT | 1.0279 |
| Davis, UT | |
| Salt Lake, UT | |
| Weber, UT | |
| San Angelo, TX | .8656 |
| Tom Green, TX | |
| San Antonio, TX | .8878 |
| Bexar, TX | |
| Comal, TX | |
| Guadalupe, TX | |
| San Diego, CA | 1.3009 |
| San Diego, CA | |
| San Francisco, CA | 1.6380 |
| Marin, CA | |
| San Francisco, CA | |
| San Mateo, CA | |
| San Jose, CA | 1.4698 |
| Santa Clara, CA | |
| Santa Barbara-Santa Maria-Lompoc, CA | 1.1749 |
| Santa Barbara, CA | |
| Santa Cruz, CA | 1.2343 |
| Santa Cruz, CA | |
| Santa Fe, NM | .9738 |
| Los Alamos, NM | |
| Santa Fe, NM | |
| Santa Rosa-Petaluma, CA | 1.3017 |
| Sonoma, CA | |
| Sarasota, FL | .9569 |
| Sarasota, FL | |
| Savannah, GA | .8853 |
| Chatham, GA | |
| Effingham, GA | |
| Scranton-Wilkes Barre, PA | .9910 |
| Columbia, PA | |
| Lackawanna, PA | |
| Luzerne, PA | |
| Monroe, PA | |
| Wyoming, PA | |
| Seattle, WA | 1.1495 |
| King, WA | |
| Snohomish, WA | |
| Sharon, PA | .9687 |
| Mercer, PA | |
| Sheboygan, WI | .9813 |
| Sheboygan, WI | |
| Sherman-Denison, TX | .8557 |
| Grayson, TX | |
| Shreveport, LA | .9543 |
| Bossier, LA | |
| Caddo, LA | |
| Sioux City, IA-NE | .9989 |
| Woodbury, IA | |
| Dakota, NE | |
| Sioux Falls, SD | 1.0137 |
| Minnehaha, SD | |
| South Bend-Mishawaka, IN | 1.0014 |
| St. Joseph, IN | |
| Spokane, WA | 1.1475 |
| Spokane, WA | |
| Springfield, IL | 1.0587 |
| Menard, IL | |
| Sangamon, IL | |
| Springfield, MO | .9792 |
| Christian, MO | |
| Greene, MO | |
| Springfield, MA | .9988 |
| Hampden, MA | |
| Hampshire, MA | |
| State College, PA | 1.0694 |
| Centre, PA | |
| Steubenville-Wairton, OH-WV | .9585 |
| Jefferson, OH | |
| Brooke, WV | |
| Hancock, WV | |
| Stockton, CA | 1.2778 |
| San Joaquin, CA | |
| Syracuse, NY | 1.0389 |
| Madison, NY | |
| Onondaga, NY | |
| Oswego, NY | |
| Tacoma, WA | 1.0972 |
| Pierce, WA | |
| Tallahassee, FL | .9441 |
| Gadsden, FL | |
| Leon, FL | |
| Tampa-St. Petersburg-Clearwater, FL | .9759 |
| Hernando, FL | |
| Hillsborough, FL | |
| Pasco, FL | |
| Pinellas, FL | |
| Terre Haute, IN | .8395 |
| Clay, IN | |
| Vigo, IN | |
| Texarkana-TX-Texarkana, AR | .8588 |
| Miller, AR | |
| Bowie, TX | |
| Toledo, OH | 1.2178 |
| Fulton, OH | |
| Lucas, OH | |
| Wood, OH | |
| Topeka, KS | 1.0555 |
| Shawnee, KS | |
| Trenton, NJ | 1.0242 |
| Mercer, NJ | |
| Tucson, AZ | 1.0017 |
| Pima, AZ | |
| Tulsa, OK | 1.0058 |
| Creeks, OK | |
| Osage, OK | |
| Rogers, OK | |
| Tulsa, OK | |
| Wagoner, OK | |
| Tuscaloosa, AL | 1.0099 |
| Tuscaloosa, AL | |
| Tyler, TX | .9963 |
| Smith, TX | |
| Utica-Rome, NY | .8667 |
| Herkimer, NY | |
| Oneida, NY | |
| Vallejo-Fairfield-Napa, CA | 1.3300 |
| Napa, CA | |
| Solano, CA | |
| Vancouver, WA | 1.1574 |
| Clark, WA | |
| Victoria, TX | .8145 |
| Victoria, TX | |
| Vineland-Millville-Bridgeton, NJ | .9858 |
| Cumberland, NJ | |
| Visalia-Tulare-Porterville, CA | 1.0566 |
| Tulare, CA | |
| Waco, TX | .9051 |
| McLennan, TX | |
| Washington, D.C.-MD-VA | 1.1878 |
| District of Columbia, DC | |
| Calvert, MD | |
| Charles, MD | |
| Frederick, MD | |
| Montgomery, MD | |
| Prince Georges, MD | |
| Alexandria City, VA | |
| Arlington, VA | |
| Fairfax, VA | |
| Fairfax City, VA | |
| Falls Church City, VA | |
| Loudoun, VA | |
| Manassas City, VA | |
| Manassas Park City, VA | |
| Prince William, VA | |
| Stafford, VA | |
| Waterloo-Cedar Falls, IA | .9920 |
| Black Hawk, IA | |
| Bremer, IA | |
| Wausau, WI | .9800 |
| Marathon, WI | |
| West Palm Beach-Boca Raton-Delary Beach, FL | .9900 |
| Palm Beach, FL | |
| Wheeling, WV-OH | .9700 |
| Belmont, OH | |
| Marshall, WV | |
| Ohio, WV | |
| Wichita, KS | 1.1506 |

## TABLE 4a.—WAGE INDEX FOR URBAN AREAS—Continued

| Urban area (constituent counties or county equivalents) | Wage index |
|---|---|
| Butler, KS | |
| Sedgwick, KS | |
| Wichita Falls, TX | .8712 |
| Wichita, TX | |
| Williamsport, PA | .8983 |
| Lycoming, PA | |
| Wilmington, DE-NJ-MD | 1.0511 |
| New Castle, DE | |
| Cecil, MD | |
| Salem, NJ | |
| Wilmington, NC | .9522 |
| New Hanover, NC | |
| Worcester-Fitchburg-Leominster, MA | .9961 |
| Worcester, MA | |
| Yakima, WA | 1.0314 |
| Yakima, WA | |
| York, PA | .9782 |
| Adams, PA | |
| York, PA | |
| Youngstown-Warren, OH | 1.0404 |
| Mahoning, OH | |
| Trumbull, OH | |
| Yuba City, CA | 1.0385 |
| Sutter, CA | |
| Yuba, CA | |

## TABLE 4B.—WAGE INDEX FOR RURAL AREAS

| Non-urban area | Wage index |
|---|---|
| Alabama | .7412 |
| Alaska | 1.4880 |
| Arizona | .9255 |
| Arkansas | .7647 |
| California | 1.1374 |
| Colorado | .9258 |
| Connecticut | 1.0384 |
| Delaware | .8582 |
| Florida | .8751 |
| Georgia | .7723 |
| Hawaii | 1.0084 |
| Idaho | .9064 |
| Illinois | .9726 |
| Indiana | .8622 |
| Iowa | .8656 |
| Kansas | .8419 |
| Kentucky | .7978 |
| Louisiana | .8543 |
| Maine | .8585 |
| Maryland | .8710 |
| Massachusetts | 1.0516 |
| Michigan | .9520 |
| Minnesota | .8725 |
| Mississippi | .7650 |
| Missouri | .8265 |
| Montana | .9087 |
| Nebraska | .8250 |

## TABLE 4B.—WAGE INDEX FOR RURAL AREAS—Continued

| Non-urban area | Wage index |
|---|---|
| Nevada | 1.0721 |
| New Hampshire | .9185 |
| New Jersey [1] | |
| New Mexico | .9146 |
| New York | .8766 |
| North Carolina | .8071 |
| North Dakota | .8995 |
| Ohio | .9034 |
| Oklahoma | .8401 |
| Oregon | 1.0704 |
| Pennsylvania | .9359 |
| Rhode Island [1] | |
| South Carolina | .7770 |
| South Dakota | .8203 |
| Tennessee | .7677 |
| Texas | .8121 |
| Utah | .9436 |
| Vermont | .8824 |
| Virginia | .8167 |
| Washington | 1.0199 |
| West Virginia | .8752 |
| Wisconsin | .8929 |
| Wyoming | .9674 |

[1] All counties within the State are classified urban.

BILLING CODE 4120-01-M

TABLE 5



LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, ARITHMETIC AND GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

| DRG | MDC | | TITLE | RELATIVE WEIGHTS | ARITHMETIC MEAN LOS | GEOMETRIC MEAN LOS | OUTLIER THRESHOLD |
|---|---|---|---|---|---|---|---|
| 1 | 1 | SURG | CRANIOTOMY AGE >17 EXCEPT FOR TRAUMA | 3.5632 | 21.4 | 16.2 | 33 |
| 2 | 1 | SURG | CRANIOTOMY FOR TRAUMA AGE >17 | 3.8117 | 19.7 | 13.4 | 30 |
| 3 | 1 | SURG * | CRANIOTOMY AGE <18 | 2.9183 | | 12.7 | 30 |
| 4 | 1 | SURG | SPINAL PROCEDURES | 2.7300 | 20.2 | 15.0 | 32 |
| 5 | 1 | SURG | EXTRACRANIAL VASCULAR PROCEDURES | 1.6510 | 9.7 | 8.0 | 25 |
| 6 | 1 | SURG | CARPAL TUNNEL RELEASE | .4072 | 2.8 | 2.3 | 7 |
| 7 | 1 | SURG | PERIPH + CRANIAL NERVE + OTHER NERV SYST PROC AGE >69 +/OR C.C. | 1.3867 | 11.5 | 6.1 | 23 |
| 8 | 1 | SURG | PERIPH + CRANIAL NERVE + OTHER NERV SYST PROC AGE <70 W/O C.C. | .7466 | 5.6 | 3.7 | 19 |
| 9 | 1 | MED | SPINAL DISORDERS + INJURIES | 1.4237 | 14.4 | 8.4 | 25 |
| 10 | 1 | MED | NERVOUS SYSTEM NEOPLASMS AGE >69 AND/OR C.C. | 1.1324 | 11.6 | 7.8 | 25 |
| 11 | 1 | MED | NERVOUS SYSTEM NEOPLASMS AGE <70 W/O C.C. | .9338 | 10.2 | 6.1 | 23 |
| 12 | 1 | MED | DEGENERATIVE NERVOUS SYSTEM DISORDERS | 1.0016 | 11.4 | 7.8 | 25 |
| 13 | 1 | MED | MULTIPLE SCLEROSIS + CEREBELLAR ATAXIA | .9789 | 10.9 | 7.7 | 25 |
| 14 | 1 | MED | SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA | 1.3144 | 12.6 | 8.5 | 26 |
| 15 | 1 | MED | TRANSIENT ISCHEMIC ATTACK AND PRECEREBRAL OCCLUSIONS | .6241 | 6.1 | 4.7 | 19 |
| 16 | 1 | MED | NONSPECIFIC CEREBROVASCULAR DISORDERS WITH C.C. | .9044 | 8.9 | 6.8 | 24 |
| 17 | 1 | MED | NONSPECIFIC CEREBROVASCULAR DISORDERS W/O C.C. | .6803 | 7.8 | 5.6 | 23 |
| 18 | 1 | MED | CRANIAL + PERIPHERAL NERVE DISORDERS AGE >69 AND/OR C.C. | .7567 | 8.2 | 6.1 | 23 |
| 19 | 1 | MED | CRANIAL + PERIPHERAL NERVE DISORDERS AGE <70 W/O C.C. | .6548 | 7.2 | 5.3 | 22 |
| 20 | 1 | MED | NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS | 1.4090 | 11.5 | 7.8 | 25 |
| 21 | 1 | MED | VIRAL MENINGITIS | 1.3144 | 10.6 | 7.9 | 25 |
| 22 | 1 | MED | HYPERTENSIVE ENCEPHALOPATHY | .7087 | 6.5 | 5.0 | 20 |
| 23 | 1 | MED | NONTRAUMATIC STUPOR + COMA | 1.1242 | 8.5 | 5.2 | 22 |
| 24 | 1 | MED | SEIZURE + HEADACHE AGE >69 AND/OR C.C. | .7644 | 6.8 | 5.0 | 22 |
| 25 | 1 | MED | SEIZURE + HEADACHE AGE 18-69 W/O C.C. | .5522 | 5.5 | 4.0 | 18 |
| 26 | 1 | MED | SEIZURE + HEADACHE AGE 0-17 | .6255 | 3.9 | 2.7 | 14 |
| 27 | 1 | MED | TRAUMATIC STUPOR + COMA, COMA >1 HR | 1.5648 | 9.8 | 4.7 | 22 |
| 28 | 1 | MED | TRAUMATIC STUPOR + COMA, COMA <1 HR AGE >69 AND/OR C.C. | .9422 | 8.5 | 5.0 | 22 |
| 29 | 1 | MED | TRAUMATIC STUPOR + COMA <1 HR AGE 18-69 W/O C.C. | .6462 | 6.0 | 3.6 | 21 |
| 30 | 1 | MED * | TRAUMATIC STUPOR + COMA <1 HR AGE 0-17 | .3539 | | 2.0 | 8 |
| 31 | 1 | MED | CONCUSSION AGE >69 AND/OR C.C. | .5383 | 5.7 | 3.9 | 20 |
| 32 | 1 | MED | CONCUSSION AGE 18-69 W/O C.C. | .4064 | 4.1 | 2.9 | 14 |
| 33 | 1 | MED * | CONCUSSION AGE 0-17 | .2457 | | 1.6 | 5 |
| 34 | 1 | MED | OTHER DISORDERS OF NERVOUS SYSTEM AGE >69 AND/OR C.C. | .9777 | 8.9 | 6.1 | 23 |
| 35 | 1 | MED | OTHER DISORDERS OF NERVOUS SYSTEM AGE <70 W/O C.C. | .7384 | 7.6 | 4.9 | 22 |

* MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.
** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.
NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER CASES.
NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.
NOTE: ARITHMETIC MEAN INCLUDED FOR COMPARATIVE PURPOSES. IT IS NOT USED FOR PAYMENT.

TABLE 5

LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, ARITHMETIC AND GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

| DRG | MDC | | TITLE | RELATIVE WEIGHTS | ARITHMETIC MEAN LOS | GEOMETRIC MEAN LOS | OUTLIER THRESHOLD |
|---|---|---|---|---|---|---|---|
| 36 | 2 SURG | | RETINAL PROCEDURES | .7103 | 4.7 | 4.1 | 12 |
| 37 | 2 SURG | | ORBITAL PROCEDURES | .6688 | 4.2 | 3.2 | 12 |
| 38 | 2 SURG | | PRIMARY IRIS PROCEDURES | .3990 | 3.1 | 2.4 | 8 |
| 39 | 2 SURG | | LENS PROCEDURES WITH OR WITHOUT VITRECTOMY | .5721 | 2.3 | 2.1 | 4 |
| 40 | 2 SURG | | EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17 | .4129 | 2.5 | 2.1 | 6 |
| 41 | 2 SURG | * | EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17 | .3657 | | 1.6 | 4 |
| 42 | 2 SURG | | INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS + LENS | .6543 | 3.7 | 3.0 | 10 |
| 43 | 2 MED | | HYPHEMA | .3462 | 4.6 | 3.7 | 15 |
| 44 | 2 MED | | ACUTE MAJOR EYE INFECTIONS | .6397 | 7.3 | 5.9 | 21 |
| 45 | 2 MED | | NEUROLOGICAL EYE DISORDERS | .5409 | 4.7 | 3.6 | 14 |
| 46 | 2 MED | | OTHER DISORDERS OF THE EYE AGE >17 WITH C.C. | .6010 | 5.6 | 3.7 | 21 |
| 47 | 2 MED | | OTHER DISORDERS OF THE EYE AGE >17 W/O C.C. | .4192 | 3.6 | 2.5 | 11 |
| 48 | 2 MED | * | OTHER DISORDERS OF THE EYE AGE 0-17 | .4018 | | 2.9 | 13 |
| 49 | 3 SURG | | MAJOR HEAD + NECK PROCEDURES | 2.8745 | 17.1 | 13.1 | 30 |
| 50 | 3 SURG | | SIALOADENECTOMY | .7034 | 4.4 | 3.7 | 11 |
| 51 | 3 SURG | | SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY | .5887 | 4.0 | 3.3 | 10 |
| 52 | 3 SURG | | CLEFT LIP + PALATE REPAIR | .6956 | 4.4 | 3.5 | 13 |
| 53 | 3 SURG | | SINUS + MASTOID PROCEDURES AGE >17 | .6176 | 3.8 | 3.0 | 10 |
| 54 | 3 SURG | * | SINUS + MASTOID PROCEDURES AGE 0-17 | .6889 | | 3.2 | 11 |
| 55 | 3 SURG | | MISCELLANEOUS EAR, NOSE + THROAT PROCEDURES | .4342 | 2.6 | 2.1 | 6 |
| 56 | 3 SURG | | RHINOPLASTY | .4358 | 2.8 | 2.3 | 7 |
| 57 | 3 SURG | | T+A PROC EXCEPT TONSILLECTOMY +/OR ADENOIDECTOMY ONLY, AGE >17 | .7718 | 5.7 | 3.7 | 20 |
| 58 | 3 SURG | * | T+A PROC EXCEPT TONSILLECTOMY +/OR ADENOIDECTOMY ONLY, AGE 0-17 | .3097 | | 1.5 | 3 |
| 59 | 3 SURG | | TONSILLECTOMY AND/OR ADENOIDECTOMY ONLY AGE >17 | .4132 | 2.9 | 2.3 | 7 |
| 60 | 3 SURG | * | TONSILLECTOMY AND/OR ADENOIDECTOMY ONLY AGE 0-17 | .2616 | | 1.5 | 3 |
| 61 | 3 SURG | | MYRINGOTOMY WITH TUBE INSERTION AGE >17 | .4274 | 2.9 | 2.0 | 8 |
| 62 | 3 SURG | * | MYRINGOTOMY WITH TUBE INSERTION AGE 0-17 | .3089 | | 1.3 | 3 |
| 63 | 3 SURG | | OTHER EAR, NOSE + THROAT O.R. PROCEDURES | 1.1619 | 8.1 | 5.1 | 22 |
| 64 | 3 MED | | EAR, NOSE + THROAT MALIGNANCY | .9769 | 8.5 | 4.8 | 22 |
| 65 | 3 MED | | DYSEQUILIBRIUM | .4499 | 4.8 | 3.8 | 14 |
| 66 | 3 MED | | EPISTAXIS | .4146 | 4.3 | 3.3 | 13 |
| 67 | 3 MED | | EPIGLOTTITIS | .9364 | 6.5 | 4.8 | 21 |
| 68 | 3 MED | | OTITIS MEDIA + URI AGE >69 AND/OR C.C. | .6092 | 6.3 | 5.1 | 17 |
| 69 | 3 MED | | OTITIS MEDIA + URI AGE 18-69 W/O C.C. | .5040 | 5.1 | 4.1 | 14 |
| 70 | 3 MED | | OTITIS MEDIA + URI AGE 0-17 | .5251 | 4.2 | 3.3 | 12 |

* MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.
** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.
NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER CASES.
NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.
NOTE: ARITHMETIC MEAN INCLUDED FOR COMPARATIVE PURPOSES. IT IS NOT USED FOR PAYMENT.

TABLE 5

LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, ARITHMETIC AND GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

| DRG | MDC | | TITLE | RELATIVE WEIGHTS | ARITHMETIC MEAN LOS | GEOMETRIC MEAN LOS | OUTLIER THRESHOLD |
|---|---|---|---|---|---|---|---|
| 71 | 3 MED | | LARYNGOTRACHEITIS | .6594 | 5.8 | 4.6 | 18 |
| 72 | 3 MED | | NASAL TRAUMA + DEFORMITY | .5217 | 5.2 | 3.5 | 19 |
| 73 | 3 MED | | OTHER EAR, NOSE + THROAT DIAGNOSES AGE >17 | .6049 | 5.1 | 3.4 | 18 |
| 74 | 3 MED | * | OTHER EAR, NOSE + THROAT DIAGNOSES AGE 0-17 | .3427 | | 2.1 | 9 |
| 75 | 4 SURG | | MAJOR CHEST PROCEDURES | 2.9780 | 16.2 | 13.4 | 30 |
| 76 | 4 SURG | | OTHER RESPIRATORY SYSTEM O.R. PROCEDURES WITH C.C. | 2.5667 | 14.9 | 10.3 | 27 |
| 77 | 4 SURG | | OTHER RESPIRATORY SYSTEM O.R. PROCEDURES W/O C.C. | 1.6735 | 11.5 | 7.0 | 24 |
| 78 | 4 MED | | PULMONARY EMBOLISM | 1.4802 | 11.7 | 9.5 | 27 |
| 79 | 4 MED | | RESPIRATORY INFECTIONS + INFLAMMATIONS AGE >69 AND/OR C.C. | 1.9546 | 13.0 | 9.6 | 27 |
| 80 | 4 MED | | RESPIRATORY INFECTIONS + INFLAMMATIONS AGE 18-69 W/O C.C. | 1.4403 | 12.2 | 8.5 | 26 |
| 81 | 4 MED | * | RESPIRATORY INFECTIONS + INFLAMMATIONS AGE 0-17 | .8652 | | 6.1 | 23 |
| 82 | 4 MED | | RESPIRATORY NEOPLASMS | 1.1259 | 9.9 | 6.6 | 24 |
| 83 | 4 MED | | MAJOR CHEST TRAUMA AGE >69 AND/OR C.C. | .8398 | 8.6 | 6.6 | 24 |
| 84 | 4 MED | | MAJOR CHEST TRAUMA AGE <70 W/O C.C. | .5921 | 6.0 | 4.6 | 19 |
| 85 | 4 MED | | PLEURAL EFFUSION AGE >69 AND/OR C.C. | 1.1198 | 9.9 | 7.2 | 24 |
| 86 | 4 MED | | PLEURAL EFFUSION AGE <70 W/O C.C. | .9761 | 8.8 | 5.9 | 23 |
| 87 | 4 MED | | PULMONARY EDEMA + RESPIRATORY FAILURE | 1.8078 | 10.2 | 7.0 | 24 |
| 88 | 4 MED | | CHRONIC OBSTRUCTIVE PULMONARY DISEASE | 1.0769 | 8.5 | 6.6 | 24 |
| 89 | 4 MED | | SIMPLE PNEUMONIA + PLEURISY AGE >69 AND/OR C.C. | 1.1768 | 9.6 | 7.5 | 25 |
| 90 | 4 MED | | SIMPLE PNEUMONIA + PLEURISY AGE 18-69 W/O C.C. | .8900 | 7.7 | 6.2 | 22 |
| 91 | 4 MED | | SIMPLE PNEUMONIA + PLEURISY AGE 0-17 | .8216 | 5.7 | 4.4 | 19 |
| 92 | 4 MED | | INTERSTITIAL LUNG DISEASE AGE >69 AND/OR C.C. | 1.1117 | 9.0 | 6.8 | 24 |
| 93 | 4 MED | | INTERSTITIAL LUNG DISEASE AGE <70 W/O C.C. | .8642 | 7.5 | 5.4 | 22 |
| 94 | 4 MED | | PNEUMOTHORAX AGE >69 AND/OR C.C. | 1.3044 | 10.1 | 7.6 | 25 |
| 95 | 4 MED | | PNEUMOTHORAX AGE <70 W/O C.C. | .8797 | 7.8 | 5.9 | 23 |
| 96 | 4 MED | | BRONCHITIS + ASTHMA AGE >69 AND/OR C.C. | .8448 | 7.3 | 6.0 | 20 |
| 97 | 4 MED | | BRONCHITIS + ASTHMA AGE 18-69 W/O C.C. | .7092 | 6.2 | 5.1 | 17 |
| 98 | 4 MED | | BRONCHITIS + ASTHMA AGE 0-17 | .7202 | 4.5 | 3.8 | 12 |
| 99 | 4 MED | | RESPIRATORY SIGNS + SYMPTOMS AGE >69 AND/OR C.C. | .8078 | 6.4 | 4.6 | 22 |
| 100 | 4 MED | | RESPIRATORY SIGNS + SYMPTOMS AGE <70 W/O C.C. | .6255 | 5.0 | 3.6 | 16 |
| 101 | 4 MED | | OTHER RESPIRATORY SYSTEM DIAGNOSES AGE >69 AND/OR C.C. | .8461 | 7.5 | 5.5 | 23 |
| 102 | 4 MED | | OTHER RESPIRATORY SYSTEM DIAGNOSES AGE <70 WITHOUT C.C. | .6843 | 6.1 | 4.3 | 21 |
| 103 | 5 SURG | | HEART TRANSPLANT | .0000 | | | |
| 104 | 5 SURG | | CARDIAC VALVE PROCEDURE WITH PUMP + WITH CARDIAC CATH | 7.3161 | 21.0 | 18.0 | 35 |
| 105 | 5 SURG | | CARDIAC VALVE PROCEDURE WITH PUMP + W/O CARDIAC CATH | 6.3400 | 18.2 | 15.0 | 32 |

* MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.
** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.
NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER CASES.
NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.
NOTE: ARITHMETIC MEAN INCLUDED FOR COMPARATIVE PURPOSES. IT IS NOT USED FOR PAYMENT.

TABLE 5



LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, ARITHMETIC AND GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

| DRG | MDC | | TITLE | RELATIVE WEIGHTS | ARITHMETIC MEAN LOS | GEOMETRIC MEAN LOS | OUTLIER THRESHOLD |
|---|---|---|---|---|---|---|---|
| 106 | 5 SURG | | CORONARY BYPASS WITH CARDIAC CATH | 5.3332 | 16.3 | 14.7 | 32 |
| 107 | 5 SURG | | CORONARY BYPASS W/O CARDIAC CATH | 4.6614 | 14.5 | 12.7 | 30 |
| 108 | 5 SURG | | OTHER CARDIOVASCULAR OR THORACIC PROC, WITH PUMP | 4.7810 | 14.7 | 10.6 | 28 |
| 109 | 5 SURG | | CARDIOTHORACIC PROCEDURES W/O PUMP | 4.3597 | 14.7 | 9.0 | 26 |
| 110 | 5 SURG | | MAJOR RECONSTRUCTIVE VASCULAR PROC W/O PUMP AGE >69 AND/OR C.C. | 3.3215 | 16.4 | 13.1 | 30 |
| 111 | 5 SURG | | MAJOR RECONSTRUCTIVE VASCULAR PROC W/O PUMP AGE <70 W/O C.C. | 2.4581 | 13.1 | 11.2 | 28 |
| 112 | 5 SURG | | VASCULAR PROCEDURES EXCEPT MAJOR RECONSTRUCTION W/O PUMP | 2.2239 | 11.8 | 8.1 | 25 |
| 113 | 5 SURG | | AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB + TOE | 2.5406 | 21.8 | 17.2 | 34 |
| 114 | 5 SURG | | UPPER LIMB + TOE AMPUTATION FOR CIRC SYSTEM DISORDERS | 1.8946 | 17.2 | 12.4 | 29 |
| 115 | 5 SURG | | PERM CARDIAC PACEMAKER IMPLANT WITH AMI, HEART FAILURE OR SHOCK | 4.1634 | 16.6 | 13.9 | 31 |
| 116 | 5 SURG | | PERM CARDIAC PACEMAKER IMPLANT W/O AMI, HEART FAILURE OR SHOCK | 2.9709 | 9.6 | 7.8 | 25 |
| 117 | 5 SURG | | CARDIAC PACEMAKER REPLACE + REVIS EXC PULSE GEN REPL ONLY | 1.4684 | 6.5 | 4.8 | 20 |
| 118 | 5 SURG | | CARDIAC PACEMAKER PULSE GENERATOR REPLACEMENT ONLY | 1.8784 | 4.7 | 3.4 | 14 |
| 119 | 5 SURG | | VEIN LIGATION + STRIPPING | .9165 | 7.7 | 5.6 | 23 |
| 120 | 5 SURG | | OTHER CIRCULATORY SYSTEM O.R. PROCEDURES | 2.2580 | 17.0 | 11.4 | 28 |
| 121 | 5 MED | | CIRCULATORY DISORDERS WITH AMI + C.V. COMP. DISCH. ALIVE | 1.7694 | 12.4 | 10.3 | 27 |
| 122 | 5 MED | | CIRCULATORY DISORDERS WITH AMI W/O C.V. COMP. DISCH. ALIVE | 1.3270 | 10.6 | 8.8 | 26 |
| 123 | 5 MED | | CIRCULATORY DISORDERS WITH AMI, EXPIRED | 1.3525 | 5.6 | 3.0 | 20 |
| 124 | 5 MED | | CIRCULATORY DISORDERS EXC AMI,WITH CARD CATH + COMPLEX DIAG | 1.2553 | 7.1 | 5.0 | 22 |
| 125 | 5 MED | | CIRCULATORY DISORDERS EXC AMI,WITH CARD CATH W/O COMPLEX DIAG | .7266 | 3.8 | 2.8 | 11 |
| 126 | 5 MED | | ACUTE + SUBACUTE ENDOCARDITIS | 2.9840 | 23.8 | 18.1 | 35 |
| 127 | 5 MED | | HEART FAILURE + SHOCK | 1.0100 | 8.9 | 6.8 | 24 |
| 128 | 5 MED | | DEEP VEIN THROMBOPHLEBITIS | .8456 | 9.9 | 8.6 | 24 |
| 129 | 5 MED | | CARDIAC ARREST, UNEXPLAINED | 1.7200 | 7.9 | 3.8 | 21 |
| 130 | 5 MED | | PERIPHERAL VASCULAR DISORDERS AGE >69 AND/OR C.C. | .8254 | 8.3 | 5.7 | 23 |
| 131 | 5 MED | | PERIPHERAL VASCULAR DISORDERS AGE <70 W/O C.C. | .6712 | 6.7 | 4.5 | 22 |
| 132 | 5 MED | | ATHEROSCLEROSIS AGE >69 AND/OR C.C. | .8040 | 7.0 | 5.3 | 22 |
| 133 | 5 MED | | ATHEROSCLEROSIS AGE <70 W/O C.C. | .7050 | 5.2 | 3.8 | 16 |
| 134 | 5 MED | | HYPERTENSION | .6365 | 6.6 | 5.1 | 20 |
| 135 | 5 MED | | CARDIAC CONGENITAL + VALVULAR DISORDERS AGE >69 AND/OR C.C. | .8936 | 7.3 | 5.3 | 22 |
| 136 | 5 MED | | CARDIAC CONGENITAL + VALVULAR DISORDERS AGE 18-69 W/O C.C. | .7526 | 5.6 | 3.8 | 18 |
| 137 | 5 MED | * | CARDIAC CONGENITAL + VALVULAR DISORDERS AGE 0-17 | .6315 | | 3.3 | 20 |
| 138 | 5 MED | | CARDIAC ARRHYTHMIA + CONDUCTION DISORDERS AGE >69 AND/OR C.C. | .8138 | 6.5 | 4.9 | 21 |
| 139 | 5 MED | | CARDIAC ARRHYTHMIA + CONDUCTION DISORDERS AGE <70 W/O C.C. | .6517 | 5.1 | 3.9 | 16 |
| 140 | 5 MED | | ANGINA PECTORIS | .6895 | 5.7 | 4.6 | 16 |

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** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.
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NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.
NOTE: ARITHMETIC MEAN INCLUDED FOR COMPARATIVE PURPOSES. IT IS NOT USED FOR PAYMENT.

LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, ARITHMETIC AND GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

| DRG | MDC | | TITLE | RELATIVE WEIGHTS | ARITHMETIC MEAN LOS | GEOMETRIC MEAN LOS | OUTLIER THRESHOLD |
|---|---|---|---|---|---|---|---|
| 141 | 5 | MED | SYNCOPE + COLLAPSE AGE >69 AND/OR C.C. | .6188 | 5.7 | 4.4 | 18 |
| 142 | 5 | MED | SYNCOPE + COLLAPSE AGE <70 W/O C.C. | .5335 | 4.7 | 3.6 | 14 |
| 143 | 5 | MED | CHEST PAIN | .5895 | 4.5 | 3.5 | 13 |
| 144 | 5 | MED | OTHER CIRCULATORY SYSTEM DIAGNOSES WITH C.C. | 1.1158 | 8.4 | 6.2 | 23 |
| 145 | 5 | MED | OTHER CIRCULATORY SYSTEM DIAGNOSES W/O C.C. | .8477 | 7.1 | 5.0 | 22 |
| 146 | 6 | SURG | RECTAL RESECTION AGE >69 AND/OR C.C. | 3.0755 | 18.9 | 16.6 | 34 |
| 147 | 6 | SURG | RECTAL RESECTION AGE <70 W/O C.C. | 2.2737 | 15.4 | 14.0 | 31 |
| 148 | 6 | SURG | MAJOR SMALL + LARGE BOWEL PROCEDURES AGE >69 AND/OR C.C. | 2.9407 | 17.8 | 15.3 | 32 |
| 149 | 6 | SURG | MAJOR SMALL + LARGE BOWEL PROCEDURES AGE <70 W/O C.C. | 2.1072 | 14.3 | 12.6 | 30 |
| 150 | 6 | SURG | PERITONEAL ADHESIOLYSIS AGE >69 AND/OR C.C. | 2.3428 | 14.9 | 12.8 | 30 |
| 151 | 6 | SURG | PERITONEAL ADHESIOLYSIS AGE <70 W/O C.C. | 1.5902 | 11.5 | 10.1 | 27 |
| 152 | 6 | SURG | MINOR SMALL + LARGE BOWEL PROCEDURES AGE >69 AND/OR C.C. | 1.4069 | 10.8 | 8.6 | 26 |
| 153 | 6 | SURG | MINOR SMALL + LARGE BOWEL PROCEDURES AGE <70 W/O C.C. | 1.0993 | 9.1 | 7.3 | 24 |
| 154 | 6 | SURG | STOMACH, ESOPHAGEAL + DUODENAL PROCEDURES AGE >69 AND/OR C.C. | 2.6880 | 15.1 | 11.5 | 29 |
| 155 | 6 | SURG | STOMACH, ESOPHAGEAL + DUODENAL PROCEDURES AGE 18-69 W/O C.C. | 1.7906 | 11.7 | 8.9 | 26 |
| 156 | 6 | SURG * | STOMACH, ESOPHAGEAL + DUODENAL PROCEDURES AGE 0-17 | .8382 | | 6.0 | 20 |
| 157 | 6 | SURG | ANAL AND STOMAL PROCEDURES AGE >69 AND/OR C.C. | .7302 | 6.4 | 4.8 | 21 |
| 158 | 6 | SURG | ANAL AND STOMAL PROCEDURES AGE <70 W/O C.C. | .5513 | 4.9 | 3.9 | 14 |
| 159 | 6 | SURG | HERNIA PROCEDURES EXCEPT INGUINAL + FEMORAL AGE >69 AND/OR C.C. | 1.0000 | 7.8 | 6.3 | 22 |
| 160 | 6 | SURG | HERNIA PROCEDURES EXCEPT INGUINAL + FEMORAL AGE 18-69 W/O C.C. | .7457 | 5.9 | 5.0 | 16 |
| 161 | 6 | SURG | INGUINAL + FEMORAL HERNIA PROCEDURES AGE >69 AND/OR C.C. | .6538 | 5.3 | 4.4 | 14 |
| 162 | 6 | SURG | INGUINAL + FEMORAL HERNIA PROCEDURES AGE 18-69 W/O C.C. | .5264 | 4.1 | 3.6 | 10 |
| 163 | 6 | SURG | HERNIA PROCEDURES AGE 0-17 | .9648 | 5.6 | 4.2 | 18 |
| 164 | 6 | SURG | APPENDECTOMY WITH COMPLICATED PRINC. DIAG AGE>69 AND/OR C.C. | 2.0649 | 12.2 | 10.7 | 28 |
| 165 | 6 | SURG | APPENDECTOMY WITH COMPLICATED PRINC. DIAG AGE <70 W/O C.C. | 1.4379 | 9.2 | 8.4 | 19 |
| 166 | 6 | SURG | APPENDECTOMY W/O COMPLICATED PRINC. DIAG AGE >69 AND/OR C.C. | 1.3606 | 9.0 | 7.5 | 23 |
| 167 | 6 | SURG | APPENDECTOMY W/O COMPLICATED PRINC. DIAG AGE <70 W/O C.C. | .8855 | 6.0 | 5.3 | 13 |
| 168 | 6 | SURG | MOUTH PROCEDURES AGE >69 AND/OR C.C. | .9188 | 6.2 | 4.8 | 21 |
| 169 | 6 | SURG | MOUTH PROCEDURES AGE <70 W/O C.C. | .6585 | 4.0 | 3.0 | 12 |
| 170 | 6 | SURG | OTHER DIGESTIVE SYSTEM O.R. PROCEDURES AGE >69 AND/OR C.C. | 2.7615 | 17.6 | 12.3 | 29 |
| 171 | 6 | SURG | OTHER DIGESTIVE SYSTEM O.R. PROCEDURES AGE <70 W/O C.C. | 2.3305 | 15.4 | 9.8 | 27 |
| 172 | 6 | MED | DIGESTIVE MALIGNANCY AGE >69 AND/OR C.C. | 1.0749 | 10.4 | 6.7 | 24 |
| 173 | 6 | MED | DIGESTIVE MALIGNANCY AGE <70 W/O C.C. | .9604 | 9.3 | 5.4 | 22 |
| 174 | 6 | MED | G.I. HEMORRHAGE AGE >69 AND/OR C.C. | .9075 | 7.5 | 5.8 | 23 |
| 175 | 6 | MED | G.I. HEMORRHAGE AGE <70 W/O C.C. | .7069 | 6.0 | 4.7 | 18 |

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| DRG | MDC | | TITLE | RELATIVE WEIGHTS | ARITHMETIC MEAN LOS | GEOMETRIC MEAN LOS | OUTLIER THRESHOLD |
|---|---|---|---|---|---|---|---|
| 176 | 6 MED | | COMPLICATED PEPTIC ULCER | .9318 | 8.3 | 6.3 | 23 |
| 177 | 6 MED | | UNCOMPLICATED PEPTIC ULCER >69 AND/OR C.C. | .6617 | 6.6 | 5.4 | 18 |
| 178 | 6 MED | | UNCOMPLICATED PEPTIC ULCER <70 W/O C.C. | .5556 | 5.5 | 4.6 | 15 |
| 179 | 6 MED | | INFLAMMATORY BOWEL DISEASE | .9877 | 9.6 | 7.1 | 24 |
| 180 | 6 MED | | G.I. OBSTRUCTION AGE >69 AND/OR C.C. | .7584 | 7.4 | 5.4 | 22 |
| 181 | 6 MED | | G.I. OBSTRUCTION AGE <70 W/O C.C. | .5828 | 5.8 | 4.5 | 18 |
| 182 | 6 MED | | ESOPHAGITIS,GASTROENT.+ MISC. DIGEST. DIS AGE >69 +/OR C.C. | .6034 | 6.1 | 4.8 | 18 |
| 183 | 6 MED | | ESOPHAGITIS,GASTROENT.+ MISC. DIGEST. DIS AGE 18-69 W/O C.C. | .5107 | 5.0 | 4.0 | 15 |
| 184 | 6 MED | | ESOPHAGITIS, GASTROENTERITIS + MISC. DIGEST. DISORDERS AGE 0-17 | .4828 | 3.7 | 2.6 | 12 |
| 185 | 6 MED | | DENTAL + ORAL DIS. EXC EXTRACTIONS + RESTORATIONS,AGE >17 | .7147 | 6.6 | 4.3 | 21 |
| 186 | 6 MED | * | DENTAL + ORAL DIS. EXC EXTRACTIONS + RESTORATIONS,AGE 0-17 | .4112 | | 2.9 | 11 |
| 187 | 6 MED | | DENTAL EXTRACTIONS + RESTORATIONS | .4211 | 2.9 | 2.3 | 7 |
| 188 | 6 MED | | OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >69 AND/OR C.C. | .7173 | 6.4 | 4.3 | 21 |
| 189 | 6 MED | | OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 18-69 W/O C.C. | .5272 | 4.8 | 3.3 | 17 |
| 190 | 6 MED | | OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17 | .9178 | 6.1 | 4.3 | 21 |
| 191 | 7 SURG | | MAJOR PANCREAS, LIVER + SHUNT PROCEDURES | 4.4608 | 22.0 | 18.1 | 35 |
| 192 | 7 SURG | | MINOR PANCREAS, LIVER + SHUNT PROCEDURES | 4.0442 | 21.7 | 16.7 | 34 |
| 193 | 7 SURG | | BILIARY TRACT PROC EXC TOT CHOLECYSTECTOMY AGE >69 +/OR C.C. | 2.8120 | 18.4 | 15.7 | 33 |
| 194 | 7 SURG | | BILIARY TRACT PROC EXC TOT CHOLECYSTECTOMY AGE <70 W/O C.C. | 2.1206 | 15.0 | 12.3 | 29 |
| 195 | 7 SURG | | TOTAL CHOLECYSTECTOMY WITH C.D.E. AGE >69 AND/OR C.C. | 2.2727 | 14.6 | 13.1 | 30 |
| 196 | 7 SURG | | TOTAL CHOLECYSTECTOMY WITH C.D.E. AGE <70 W/O C.C. | 1.5976 | 11.2 | 10.3 | 22 |
| 197 | 7 SURG | | TOTAL CHOLECYSTECTOMY W/O C.D.E. AGE >69 AND/OR C.C. | 1.7058 | 11.9 | 10.5 | 27 |
| 198 | 7 SURG | | TOTAL CHOLECYSTECTOMY W/O C.D.E. AGE <70 W/O C.C. | 1.1400 | 8.7 | 8.0 | 17 |
| 199 | 7 SURG | | HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY | 2.3378 | 17.4 | 14.2 | 31 |
| 200 | 7 SURG | | HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY | 2.6286 | 15.8 | 10.9 | 28 |
| 201 | 7 SURG | | OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES | 2.7130 | 16.1 | 10.4 | 27 |
| 202 | 7 MED | | CIRRHOSIS + ALCOHOLIC HEPATITIS | 1.1665 | 10.8 | 7.8 | 25 |
| 203 | 7 MED | | MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS | 1.0339 | 10.1 | 6.9 | 24 |
| 204 | 7 MED | | DISORDERS OF PANCREAS EXCEPT MALIGNANCY | .9703 | 8.2 | 6.5 | 24 |
| 205 | 7 MED | | DISORDERS OF LIVER EXC MALIG,CIRR,ALC HEPA AGE >69 AND/OR C.C. | 1.0720 | 9.5 | 6.7 | 24 |
| 206 | 7 MED | | DISORDERS OF LIVER EXC MALIG,CIRR,ALC HEPA AGE <70 W/O C.C. | .7735 | 7.5 | 5.0 | 22 |
| 207 | 7 MED | | DISORDERS OF THE BILIARY TRACT AGE >69 AND/OR C.C. | .7775 | 7.0 | 5.4 | 22 |
| 208 | 7 MED | | DISORDERS OF THE BILIARY TRACT AGE <70 W/O C.C. | .5794 | 5.2 | 4.0 | 16 |
| 209 | 8 SURG | | MAJOR JOINT AND LIMB REATTACHMENT PROCEDURES | 2.3930 | 15.8 | 14.4 | 31 |
| 210 | 8 SURG | | HIP + FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >69 AND/OR C.C. | 2.0320 | 16.9 | 14.6 | 32 |

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| DRG | MDC | | TITLE | RELATIVE WEIGHTS | ARITHMETIC MEAN LOS | GEOMETRIC MEAN LOS | OUTLIER THRESHOLD |
|---|---|---|---|---|---|---|---|
| 211 | 8 | SURG | HIP + FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 18-69 W/O C.C. | 1.7867 | 15.0 | 12.7 | 30 |
| 212 | 8 | SURG | HIP + FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17 | 1.6609 | 9.7 | 8.3 | 23 |
| 213 | 8 | SURG | AMPUTATIONS FOR MUSCULOSKELETAL SYSTEM + CONN. TISSUE DISORDERS | 1.9753 | 17.1 | 12.1 | 29 |
| 214 | 8 | SURG | BACK + NECK PROCEDURES AGE >69 AND/OR C.C. | 1.8776 | 15.6 | 13.1 | 30 |
| 215 | 8 | SURG | BACK + NECK PROCEDURES AGE <70 W/O C.C. | 1.4281 | 12.0 | 10.2 | 27 |
| 216 | 8 | SURG | BIOPSIES OF MUSCULOSKELETAL SYSTEM + CONNECTIVE TISSUE | 1.5566 | 13.7 | 8.9 | 26 |
| 217 | 8 | SURG | WND DEBRID + SKN GRFT EXC HAND,FOR MUSCSKELETAL + CONN.TISS.DIS | 2.3100 | 18.8 | 11.2 | 28 |
| 218 | 8 | SURG | LOWER EXTREM + HUMER PROC EXC HIP,FOOT,FEMUR AGE >69 +/OR C.C. | 1.3798 | 11.2 | 8.9 | 26 |
| 219 | 8 | SURG | LOWER EXTREM + HUMER PROC EXC HIP,FOOT,FEMUR AGE 18-69 W/O C.C. | 1.0437 | 8.1 | 6.7 | 22 |
| 220 | 8 | SURG * | LOWER EXTREM + HUMER PROC EXC HIP,FOOT,FEMUR AGE 0-17 | .9242 | | 5.3 | 22 |
| 221 | 8 | SURG | KNEE PROCEDURES AGE >69 AND/OR C.C. | .9758 | 7.0 | 4.7 | 22 |
| 222 | 8 | SURG | KNEE PROCEDURES AGE <70 W/O C.C. | .7113 | 4.7 | 3.4 | 15 |
| 223 | 8 | SURG | UPPER EXTREMITY PROC EXC HUMERUS + HAND AGE >69 AND/OR C.C. | .9853 | 7.1 | 5.3 | 22 |
| 224 | 8 | SURG | UPPER EXTREMITY PROC EXC HUMERUS + HAND AGE <70 W/O C.C. | .7891 | 5.2 | 4.1 | 15 |
| 225 | 8 | SURG | FOOT PROCEDURES | .6520 | 4.8 | 3.9 | 13 |
| 226 | 8 | SURG | SOFT TISSUE PROCEDURES AGE >69 AND/OR C.C. | .9811 | 8.1 | 5.4 | 22 |
| 227 | 8 | SURG | SOFT TISSUE PROCEDURES AGE <70 W/O C.C. | .6872 | 5.2 | 3.8 | 17 |
| 228 | 8 | SURG | GANGLION (HAND) PROCEDURES | .3661 | 2.3 | 1.9 | 5 |
| 229 | 8 | SURG | HAND PROCEDURES EXCEPT GANGLION | .6212 | 4.0 | 2.9 | 12 |
| 230 | 8 | SURG | LOCAL EXCISION + REMOVAL OF INT FIX DEVICES OF HIP + FEMUR | 1.0555 | 9.2 | 6.1 | 23 |
| 231 | 8 | SURG | LOCAL EXCISION + REMOVAL OF INT FIX DEVICES EXCEPT HIP + FEMUR | .7516 | 5.6 | 3.8 | 19 |
| 232 | 8 | SURG | ARTHROSCOPY | .6706 | 4.6 | 3.2 | 14 |
| 233 | 8 | SURG | OTHER MUSCULOSKELET SYS + CONN TISS O.R. PROC AGE >69 +/OR C.C. | 1.3723 | 11.5 | 8.1 | 25 |
| 234 | 8 | SURG | OTHER MUSCULOSKELET SYS + CONN TISS O.R. PROC AGE <70 W/O C.C. | .9457 | 7.5 | 5.3 | 22 |
| 235 | 8 | MED | FRACTURES OF FEMUR | 1.4137 | 17.9 | 10.1 | 27 |
| 236 | 8 | MED | FRACTURES OF HIP + PELVIS | 1.0714 | 13.1 | 8.8 | 26 |
| 237 | 8 | MED | SPRAINS, STRAINS, + DISLOCATIONS OF HIP, PELVIS + THIGH | .6049 | 7.4 | 5.4 | 22 |
| 238 | 8 | MED | OSTEOMYELITIS | 1.6470 | 15.8 | 11.1 | 28 |
| 239 | 8 | MED | PATHOLOGICAL FRACTURES + MUSCULOSKELETAL + CONN.TISS.MALIGNANCY | .9272 | 10.6 | 8.0 | 25 |
| 240 | 8 | MED | CONNECTIVE TISSUE DISORDERS AGE >69 AND/OR C.C. | .9049 | 9.5 | 7.3 | 24 |
| 241 | 8 | MED | CONNECTIVE TISSUE DISORDERS AGE <70 W/O C.C. | .7492 | 8.2 | 6.2 | 23 |
| 242 | 8 | MED | SEPTIC ARTHRITIS | 1.4562 | 13.5 | 9.7 | 27 |
| 243 | 8 | MED | MEDICAL BACK PROBLEMS | .6843 | 8.0 | 6.2 | 23 |
| 244 | 8 | MED | BONE DISEASES + SPECIFIC ARTHROPATHIES AGE >69 AND/OR C.C. | .6748 | 7.9 | 6.1 | 23 |
| 245 | 8 | MED | BONE DISEASES + SPECIFIC ARTHROPATHIES AGE <70 W/O C.C. | .6407 | 6.7 | 5.1 | 22 |

* MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.
** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.
NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER CASES.
NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.
NOTE: ARITHMETIC MEAN INCLUDED FOR COMPARATIVE PURPOSES. IT IS NOT USED FOR PAYMENT.

LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, ARITHMETIC AND GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

| DRG | MDC | | TITLE | RELATIVE WEIGHTS | ARITHMETIC MEAN LOS | GEOMETRIC MEAN LOS | OUTLIER THRESHOLD |
|---|---|---|---|---|---|---|---|
| 246 | 8 MED | | NON-SPECIFIC ARTHROPATHIES | .5936 | 6.9 | 5.4 | 21 |
| 247 | 8 MED | | SIGNS + SYMPTOMS OF MUSCULOSKELETAL SYSTEM + CONN TISSUE | .5797 | 6.4 | 4.7 | 21 |
| 248 | 8 MED | | TENDONITIS, MYOSITIS + BURSITIS | .5892 | 6.3 | 4.8 | 20 |
| 249 | 8 MED | | AFTERCARE, MUSCULOSKELETAL SYSTEM + CONNECTIVE TISSUE | .7899 | 8.8 | 5.6 | 23 |
| 250 | 8 MED | | FX,SPRNS,STRNS + DISL OF FOREARM,HAND,FOOT AGE >69 +/OR C.C. | .5162 | 5.6 | 3.8 | 20 |
| 251 | 8 MED | | FX,SPRNS,STRNS + DISL OF FOREARM,HAND,FOOT AGE 18-69 W/O C.C. | .4004 | 3.5 | 2.5 | 11 |
| 252 | 8 MED | * | FX,SPRNS,STRNS + DISL OF FOREARM,HAND,FOOT AGE 0-17 | .3496 | | 1.8 | 7 |
| 253 | 8 MED | | FX,SPRNS,STRNS + DISL OF UPARM,LOWLEG EX FOOT AGE >69 +/OR C.C. | .6323 | 7.8 | 5.4 | 22 |
| 254 | 8 MED | | FX,SPRNS,STRNS + DISL OF UPARM,LOWLEG EX FOOT AGE 18-69 W/O C.C. | .4931 | 5.8 | 4.0 | 20 |
| 255 | 8 MED | * | FX,SPRNS,STRNS + DISL OF UPARM,LOWLEG EX FOOT AGE 0-17 | .4638 | | 2.9 | 15 |
| 256 | 8 MED | | OTHER DIAGNOSES OF MUSCULOSKELETAL SYSTEM + CONNECTIVE TISSUE | .6993 | 7.2 | 4.9 | 22 |
| 257 | 9 SURG | | TOTAL MASTECTOMY FOR MALIGNANCY AGE >69 AND/OR C.C. | 1.0634 | 8.7 | 7.8 | 19 |
| 258 | 9 SURG | | TOTAL MASTECTOMY FOR MALIGNANCY AGE <70 W/O C.C. | .9698 | 7.6 | 6.9 | 16 |
| 259 | 9 SURG | | SUBTOTAL MASTECTOMY FOR MALIGNANCY AGE >69 AND/OR C.C. | .8605 | 7.0 | 4.9 | 22 |
| 260 | 9 SURG | | SUBTOTAL MASTECTOMY FOR MALIGNANCY AGE <70 W/O C.C. | .6661 | 4.8 | 3.5 | 15 |
| 261 | 9 SURG | | BREAST PROC FOR NON-MALIG EXCEPT BIOPSY + LOC EXC | .6104 | 4.1 | 3.3 | 11 |
| 262 | 9 SURG | | BREAST BIOPSY + LOCAL EXCISION FOR NON-MALIGNANCY | .4252 | 2.8 | 2.3 | 6 |
| 263 | 9 SURG | | SKIN-GRAFTS AND/OR DEBRID ULCER OR CELLULITIS AGE >69 AND/OR C.C. | 2.4177 | 22.1 | 16.1 | 33 |
| 264 | 9 SURG | | SKIN-GRAFTS AND/OR DEBRID ULCER OR CELLULITIS AGE <70 W/O C.C. | 2.1802 | 21.7 | 14.9 | 32 |
| 265 | 9 SURG | | SKIN-GRAFT AND/OR DEBRID EXC SKIN ULCER OR CELLULITIS WITH C.C. | 1.3993 | 11.6 | 7.6 | 25 |
| 266 | 9 SURG | | SKIN-GRAFT AND/OR DEBRID EXC SKIN ULCER OR CELLULITIS W/O C.C. | .7313 | 6.1 | 4.0 | 21 |
| 267 | 9 SURG | | PERIANAL + PILONIDAL PROCEDURES | .6362 | 5.4 | 4.0 | 17 |
| 268 | 9 SURG | | SKIN,SUBCUTANEOUS TISSUE + BREAST PLASTIC PROCEDURES | .5690 | 3.9 | 2.8 | 12 |
| 269 | 9 SURG | | OTHER SKIN, SUBCUT TISS + BREAST O.R. PROC AGE >69 +/OR C.C. | 1.1338 | 9.6 | 5.5 | 23 |
| 270 | 9 SURG | | OTHER SKIN, SUBCUT TISS + BREAST O.R. PROC AGE <70 W/O C.C. | .7625 | 6.3 | 3.8 | 21 |
| 271 | 9 MED | | SKIN ULCERS | 1.2609 | 14.1 | 10.1 | 27 |
| 272 | 9 MED | | MAJOR SKIN DISORDERS AGE >69 AND/OR C.C. | .8523 | 9.5 | 7.2 | 24 |
| 273 | 9 MED | | MAJOR SKIN DISORDERS AGE <70 W/O C.C. | .7972 | 9.4 | 6.5 | 24 |
| 274 | 9 MED | | MALIGNANT BREAST DISORDERS AGE >69 AND/OR C.C. | 1.0368 | 10.9 | 7.0 | 24 |
| 275 | 9 MED | | MALIGNANT BREAST DISORDERS AGE <70 W/O C.C. | .9882 | 10.4 | 5.8 | 23 |
| 276 | 9 MED | | NON-MALIGANT BREAST DISORDERS | .5676 | 5.4 | 3.4 | 19 |
| 277 | 9 MED | | CELLULITIS AGE >69 AND/OR C.C. | .8866 | 9.2 | 7.3 | 24 |
| 278 | 9 MED | | CELLULITIS AGE 18-69 W/O C.C. | .7594 | 7.9 | 6.2 | 23 |
| 279 | 9 MED | * | CELLULITIS AGE 0-17 | .4739 | | 4.2 | 13 |
| 280 | 9 MED | | TRAUMA TO THE SKIN, SUBCUT TISS + BREAST AGE >69 +/OR C.C. | .5417 | 6.4 | 4.6 | 22 |

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| DRG | MDC | | TITLE | RELATIVE WEIGHTS | ARITHMETIC MEAN LOS | GEOMETRIC MEAN LOS | OUTLIER THRESHOLD |
|---|---|---|---|---|---|---|---|
| 281 | 9 | MED | TRAUMA TO THE SKIN, SUBCUT TISS + BREAST AGE 18-69 W/O C.C. | .4468 | 4.8 | 3.4 | 16 |
| 282 | 9 | MED * | TRAUMA TO THE SKIN, SUBCUT TISS + BREAST AGE 0-17 | .3424 | | 2.2 | 9 |
| 283 | 9 | MED | MINOR SKIN DISORDERS AGE >69 AND/OR C.C. | .6368 | 7.0 | 5.0 | 22 |
| 284 | 9 | MED | MINOR SKIN DISORDERS AGE <70 W/O C.C. | .5172 | 5.3 | 3.7 | 18 |
| 285 | 10 | SURG | AMPUTATION OF LOWER LIMB FOR ENDOCRINE,NUTRITIONAL&METABOLIC DIS. | 3.2724 | 28.0 | 21.5 | 39 |
| 286 | 10 | SURG | ADRENAL + PITUITARY PROCEDURES | 2.6731 | 15.8 | 13.3 | 30 |
| 287 | 10 | SURG | SKIN GRAFTS + WOUND DEBRIDE FOR ENDOC,NUTRIT + METAB DISORDERS | 2.3781 | 21.5 | 15.7 | 33 |
| 288 | 10 | SURG | O.R. PROCEDURES FOR OBESITY | 2.1130 | 12.4 | 9.7 | 27 |
| 289 | 10 | SURG | PARATHYROID PROCEDURES | 1.3308 | 8.8 | 6.9 | 24 |
| 290 | 10 | SURG | THYROID PROCEDURES | .8563 | 5.9 | 5.0 | 14 |
| 291 | 10 | SURG | THYROGLOSSAL PROCEDURES | .6073 | 4.2 | 3.4 | 11 |
| 292 | 10 | SURG | OTHER ENDOCRINE, NUTRIT + METAB O.R. PROC AGE > 69 +/OR C.C. | 2.3131 | 16.7 | 11.3 | 28 |
| 293 | 10 | SURG | OTHER ENDOCRINE, NUTRIT + METAB O.R. PROC AGE <70 W/O C.C. | 1.7962 | 14.0 | 8.2 | 25 |
| 294 | 10 | MED | DIABETES AGE =>36 | .7454 | 8.3 | 6.7 | 24 |
| 295 | 10 | MED | DIABETES AGE 0-35 | .7886 | 6.7 | 5.0 | 22 |
| 296 | 10 | MED | NUTRITIONAL + MISC. METABOLIC DISORDERS AGE >69 AND/OR C.C. | .8271 | 8.3 | 6.1 | 23 |
| 297 | 10 | MED | NUTRITIONAL + MISC. METABOLIC DISORDERS AGE 18-69 W/O C.C. | .6998 | 7.0 | 4.9 | 22 |
| 298 | 10 | MED | NUTRITIONAL + MISC. METABOLIC DISORDERS AGE 0-17 | .7202 | 5.3 | 3.3 | 18 |
| 299 | 10 | MED | INBORN ERRORS OF METABOLISM | .8080 | 7.7 | 5.3 | 22 |
| 300 | 10 | MED | ENDOCRINE DISORDERS AGE >69 AND/OR C.C. | .9349 | 9.2 | 6.9 | 24 |
| 301 | 10 | MED | ENDOCRINE DISORDERS AGE <70 W/O C.C. | .6882 | 6.9 | 5.1 | 22 |
| 302 | 11 | SURG | KIDNEY TRANSPLANT | 4.6273 | 24.6 | 21.3 | 38 |
| 303 | 11 | SURG | KIDNEY,URETER + MAJOR BLADDER PROCEDURE FOR NEOPLASM | 2.7610 | 16.6 | 14.2 | 31 |
| 304 | 11 | SURG | KIDNEY,URETER + MAJ BLDR PROC FOR NON-NEOPL AGE >69 +/OR C.C. | 2.0323 | 13.5 | 10.8 | 28 |
| 305 | 11 | SURG | KIDNEY,URETER + MAJ BLDR PROC FOR NON-NEOPL AGE <70 W/O C.C. | 1.4894 | 10.4 | 8.4 | 25 |
| 306 | 11 | SURG | PROSTATECTOMY AGE >69 AND/OR C.C. | 1.2595 | 9.8 | 8.1 | 25 |
| 307 | 11 | SURG | PROSTATECTOMY AGE <70 W/O C.C. | .9587 | 7.7 | 6.5 | 19 |
| 308 | 11 | SURG | MINOR BLADDER PROCEDURES AGE >69 AND/OR C.C. | 1.1490 | 8.8 | 6.1 | 23 |
| 309 | 11 | SURG | MINOR BLADDER PROCEDURES AGE <70 W/O C.C. | .8665 | 6.7 | 4.7 | 22 |
| 310 | 11 | SURG | TRANSURETHRAL PROCEDURES AGE >69 AND/OR C.C. | .7266 | 5.6 | 4.3 | 17 |
| 311 | 11 | SURG | TRANSURETHRAL PROCEDURES AGE <70 W/O C.C. | .5563 | 4.1 | 3.3 | 11 |
| 312 | 11 | SURG | URETHRAL PROCEDURES, AGE >69 AND/OR C.C. | .7308 | 5.8 | 4.4 | 18 |
| 313 | 11 | SURG | URETHRAL PROCEDURES, AGE 18-69 W/O C.C. | .5936 | 4.7 | 3.5 | 14 |
| 314 | 11 | SURG * | URETHRAL PROCEDURES, AGE 0-17 | .4323 | | 2.3 | 11 |
| 315 | 11 | SURG | OTHER KIDNEY + URINARY TRACT O.R. PROCEDURES | 2.7760 | 15.4 | 9.8 | 27 |

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| DRG | MDC | | TITLE | RELATIVE WEIGHTS | ARITHMETIC MEAN LOS | GEOMETRIC MEAN LOS | OUTLIER THRESHOLD |
|---|---|---|---|---|---|---|---|
| 316 | 11 MED | | RENAL FAILURE | 1.3212 | 10.0 | 6.4 | 23 |
| 317 | 11 MED | | ADMIT FOR RENAL DIALYSIS | .4907 | 3.4 | 2.3 | 10 |
| 318 | 11 MED | | KIDNEY + URINARY TRACT NEOPLASMS AGE >69 AND/OR C.C. | .9231 | 8.8 | 5.5 | 23 |
| 319 | 11 MED | | KIDNEY + URINARY TRACT NEOPLASMS AGE <70 W/O C.C. | .7418 | 6.6 | 3.8 | 21 |
| 320 | 11 MED | | KIDNEY + URINARY TRACT INFECTIONS AGE >69 AND/OR C.C. | .8629 | 8.2 | 6.5 | 24 |
| 321 | 11 MED | | KIDNEY + URINARY TRACT INFECTIONS AGE 18-69 W/O C.C. | .6753 | 6.4 | 5.1 | 19 |
| 322 | 11 MED | | KIDNEY + URINARY TRACT INFECTIONS AGE 0-17 | .6998 | 6.4 | 5.2 | 19 |
| 323 | 11 MED | | URINARY STONES AGE >69 AND/OR C.C. | .5863 | 5.1 | 3.7 | 17 |
| 324 | 11 MED | | URINARY STONES AGE <70 W/O C.C. | .4098 | 3.6 | 2.8 | 11 |
| 325 | 11 MED | | KIDNEY + URINARY TRACT SIGNS + SYMPTOMS AGE >69 AND/OR C.C. | .6504 | 6.5 | 4.6 | 22 |
| 326 | 11 MED | | KIDNEY + URINARY TRACT SIGNS + SYMPTOMS AGE 18-69 W/O C.C. | .5159 | 4.9 | 3.5 | 16 |
| 327 | 11 MED | | KIDNEY + URINARY TRACT SIGNS + SYMPTOMS AGE 0-17 | .5511 | 28.6 | 3.3 | 20 |
| 328 | 11 MED | | URETHRAL STRICTURE AGE >69 AND/OR C.C. | .5939 | 5.4 | 4.0 | 18 |
| 329 | 11 MED | | URETHRAL STRICTURE AGE 18-69 W/O C.C. | .4870 | 4.1 | 3.0 | 12 |
| 330 | 11 MED | * | URETHRAL STRICTURE AGE 0-17 | .2788 | | 1.6 | 5 |
| 331 | 11 MED | | OTHER KIDNEY + URINARY TRACT DIAGNOSES AGE >69 AND/OR C.C. | .8333 | 7.6 | 5.4 | 22 |
| 332 | 11 MED | | OTHER KIDNEY + URINARY TRACT DIAGNOSES AGE 18-69 W/O C.C. | .6740 | 6.0 | 4.1 | 21 |
| 333 | 11 MED | | OTHER KIDNEY + URINARY TRACT DIAGNOSES AGE 0-17 | .7915 | 5.9 | 3.7 | 21 |
| 334 | 12 SURG | | MAJOR MALE PELVIC PROCEDURES WITH C.C. | 1.8038 | 13.5 | 12.3 | 28 |
| 335 | 12 SURG | | MAJOR MALE PELVIC PROCEDURES W/O C.C. | 1.4644 | 11.9 | 11.0 | 23 |
| 336 | 12 SURG | | TRANSURETHRAL PROSTATECTOMY AGE >69 AND/OR C.C. | .9871 | 7.9 | 7.0 | 18 |
| 337 | 12 SURG | | TRANSURETHRAL PROSTATECTOMY AGE <70 W/O C.C. | .7788 | 6.3 | 5.8 | 12 |
| 338 | 12 SURG | | TESTES PROCEDURES, FOR MALIGNANCY | .8907 | 7.3 | 4.9 | 22 |
| 339 | 12 SURG | | TESTES PROCEDURES, NON-MALIGNANT AGE >17 | .5766 | 4.4 | 3.4 | 12 |
| 340 | 12 SURG | * | TESTES PROCEDURES, NON-MALIGNANT AGE 0-17 | .4335 | | 2.4 | 7 |
| 341 | 12 SURG | | PENIS PROCEDURES | .9974 | 6.4 | 5.3 | 16 |
| 342 | 12 SURG | | CIRCUMCISION AGE >17 | .4266 | 3.0 | 2.4 | 8 |
| 343 | 12 SURG | * | CIRCUMCISION AGE 0-17 | .3788 | | 1.7 | 4 |
| 344 | 12 SURG | | OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY | 1.1216 | 8.3 | 6.3 | 23 |
| 345 | 12 SURG | | OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIG | .8196 | 6.5 | 4.8 | 22 |
| 346 | 12 MED | | MALIGNANCY, MALE REPRODUCTIVE SYSTEM, AGE >69 AND/OR C.C. | .8569 | 8.5 | 5.6 | 23 |
| 347 | 12 MED | | MALIGNANCY, MALE REPRODUCTIVE SYSTEM, AGE <70 W/O C.C. | .6441 | 5.9 | 3.7 | 21 |
| 348 | 12 MED | | BENIGN PROSTATIC HYPERTROPHY AGE >69 AND/OR C.C. | .6260 | 5.6 | 3.9 | 19 |
| 349 | 12 MED | | BENIGN PROSTATIC HYPERTROPHY AGE <70 W/O C.C. | .4854 | 3.9 | 2.9 | 12 |
| 350 | 12 MED | | INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM | .6270 | 5.9 | 4.8 | 17 |

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| DRG | MDC | | TITLE | RELATIVE WEIGHTS | ARITHMETIC MEAN LOS | GEOMETRIC MEAN LOS | OUTLIER THRESHOLD |
|---|---|---|---|---|---|---|---|
| 351 | 12 MED | | STERILIZATION, MALE | .3334 | 1.9 | 1.6 | 5 |
| 352 | 12 MED | | OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES | .5388 | 4.8 | 3.3 | 16 |
| 353 | 13 SURG | | PELVIC EVISCERATION, RADICAL HYSTERECTOMY + VULVECTOMY | 1.8818 | 14.0 | 10.8 | 28 |
| 354 | 13 SURG | | NON-RADICAL HYSTERECTOMY AGE >69 AND/OR C.C. | 1.2335 | 9.7 | 8.8 | 19 |
| 355 | 13 SURG | | NON-RADICAL HYSTERECTOMY AGE <70 W/O C.C. | .9767 | 7.8 | 7.4 | 13 |
| 356 | 13 SURG | | FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES | .8511 | 7.7 | 7.0 | 15 |
| 357 | 13 SURG | | UTERUS + ADENEXA PROCEDURES, FOR MALIGNANCY | 2.1101 | 14.9 | 12.3 | 29 |
| 358 | 13 SURG | | UTERUS + ADENEXA PROC FOR NON-MALIGNANCY EXCEPT TUBAL INTERRUPT | 1.1185 | 8.6 | 6.9 | 24 |
| 359 | 13 SURG | | INCISIONAL TUBAL INTERRUPTION FOR NON-MALIGNANCY | .5044 | 3.3 | 2.7 | 9 |
| 360 | 13 SURG | | VAGINA, CERVIX + VULVA PROCEDURES | .6055 | 4.8 | 3.4 | 16 |
| 361 | 13 SURG | | LAPAROSCOPY + ENDOSCOPY (FEMALE) EXCEPT TUBAL INTERRUPTION | .7063 | 4.8 | 3.2 | 17 |
| 362 | 13 SURG | | LAPAROSCOPIC TUBAL INTERRUPTION | .3596 | 2.0 | 1.8 | 4 |
| 363 | 13 SURG | | D+C,CONIZATION + RADIO-IMPLANT, FOR MALIGNANCY | .6176 | 4.9 | 3.6 | 15 |
| 364 | 13 SURG | | D+C,CONIZATION EXCEPT FOR MALIGNANCY | .3922 | 2.8 | 2.3 | 7 |
| 365 | 13 SURG | | OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES | 1.9086 | 14.0 | 10.9 | 28 |
| 366 | 13 MED | | MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM AGE >69 AND/OR C.C. | .8626 | 8.4 | 4.9 | 22 |
| 367 | 13 MED | | MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM AGE <70 W/O C.C. | .5354 | 4.7 | 2.8 | 16 |
| 368 | 13 MED | | INFECTIONS, FEMALE REPRODUCTIVE SYSTEM | .7610 | 7.8 | 5.9 | 23 |
| 369 | 13 MED | | MENSTRUAL + OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS | .5498 | 5.6 | 3.9 | 20 |
| 370 | 14 SURG | | CESAREAN SECTION WITH C.C. | 1.0856 | 7.9 | 7.1 | 16 |
| 371 | 14 SURG | | CESAREAN SECTION W/O C.C. | .7670 | 6.2 | 5.6 | 12 |
| 372 | 14 MED | | VAGINAL DELIVERY WITH COMPLICATING DIAGNOSES | .5945 | 5.2 | 4.0 | 14 |
| 373 | 14 MED | | VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES | .3538 | 3.1 | 2.8 | 7 |
| 374 | 14 SURG | | VAGINAL DELIVERY WITH STERILIZATION AND/OR D+C | .5755 | 3.7 | 3.3 | 8 |
| 375 | 14 SURG | * | VAGINAL DELIVERY WITH O.R. PROC EXCEPT STERIL AND/OR D+C | .6817 | | 4.4 | 15 |
| 376 | 14 MED | | POSTPARTUM AND POSTABORTION DIAGNOSES W/O O.R. PROCEDURE | .4523 | 4.9 | 3.3 | 16 |
| 377 | 14 SURG | | POSTPARTUM AND POSTABORTION DIAGNOSES WITH O.R. PROCEDURE | .7886 | 4.3 | 3.3 | 15 |
| 378 | 14 MED | | ECTOPIC PREGNANCY | .7358 | 5.2 | 4.3 | 14 |
| 379 | 14 MED | | THREATENED ABORTION | .2409 | 2.6 | 1.9 | 8 |
| 380 | 14 MED | | ABORTION W/O D+C | .3609 | 2.8 | 1.9 | 9 |
| 381 | 14 MED | | ABORTION WITH D+C, ASPIRATION CURETTAGE, OR HYSTEROTOMY | .3783 | 2.1 | 1.7 | 5 |
| 382 | 14 MED | | FALSE LABOR | .1137 | 1.5 | 1.2 | 3 |
| 383 | 14 MED | | OTHER ANTEPARTUM DIAGNOSES WITH MEDICAL COMPLICATIONS | .4453 | 4.8 | 3.4 | 16 |
| 384 | 14 MED | | OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS | .4586 | 4.4 | 2.6 | 16 |
| 385 | 15 | * | NEONATES, DIED OR TRANSFERRED | .6811 | | 1.8 | 14 |

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| DRG | MDC | | TITLE | RELATIVE WEIGHTS | ARITHMETIC MEAN LOS | GEOMETRIC MEAN LOS | OUTLIER THRESHOLD |
|---|---|---|---|---|---|---|---|
| 386 | 15 | * | EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE | 3.6480 | | 17.9 | 35 |
| 387 | 15 | * | PREMATURITY WITH MAJOR PROBLEMS | 1.8267 | | 13.3 | 30 |
| 388 | 15 | * | PREMATURITY W/O MAJOR PROBLEMS | 1.1571 | | 8.6 | 26 |
| 389 | 15 | * | FULL TERM NEONATE WITH MAJOR PROBLEMS | .5425 | | 4.7 | 16 |
| 390 | 15 | * | NEONATES WITH OTHER SIGNIFICANT PROBLEMS | .3486 | | 3.4 | 9 |
| 391 | 15 | * | NORMAL NEWBORNS | .2218 | | 3.1 | 7 |
| 392 | 16 | SURG | SPLENECTOMY AGE >17 | 3.2494 | 17.3 | 13.7 | 31 |
| 393 | 16 | SURG * | SPLENECTOMY AGE 0-17 | 1.5206 | | 9.1 | 26 |
| 394 | 16 | SURG | OTHER O.R. PROCEDURES OF THE BLOOD & BLOOD FORMING ORGANS | 1.0891 | 8.0 | 5.0 | 22 |
| 395 | 16 | MED | RED BLOOD CELL DISORDERS AGE >17 | .7153 | 6.7 | 4.7 | 22 |
| 396 | 16 | MED | RED BLOOD CELL DISORDERS AGE 0-17 | .2952 | 1.7 | 1.3 | 4 |
| 397 | 16 | MED | COAGULATION DISORDERS | .9971 | 8.4 | 5.9 | 23 |
| 398 | 16 | MED | RETICULOENDOTHELIAL & IMMUNITY DISORDERS AGE >69 AND/OR C.C. | .9753 | 8.1 | 5.5 | 23 |
| 399 | 16 | MED | RETICULOENDOTHELIAL & IMMUNITY DISORDERS AGE <70 W/O C.C. | .7247 | 6.4 | 4.2 | 21 |
| 400 | 17 | SURG | LYMPHOMA OR LEUKEMIA WITH MAJOR O.R. PROCEDURE | 2.6646 | 16.7 | 12.8 | 30 |
| 401 | 17 | SURG | LYMPHOMA OR LEUKEMIA WITH OTHER O.R. PROC AGE >69 AND/OR C.C. | 1.5902 | 12.3 | 8.2 | 25 |
| 402 | 17 | SURG | LYMPHOMA OR LEUKEMIA WITH OTHER O.R. PROCEDURE AGE <70 W/O C.C. | 1.0555 | 8.2 | 5.6 | 23 |
| 403 | 17 | MED | LYMPHOMA OR LEUKEMIA AGE >69 AND/OR C.C. | 1.3279 | 10.7 | 6.7 | 24 |
| 404 | 17 | MED | LYMPHOMA OR LEUKEMIA AGE 18-69 W/O C.C. | 1.0449 | 8.4 | 5.0 | 22 |
| 405 | 17 | MED * | LYMPHOMA OR LEUKEMIA AGE 0-17 | 1.0407 | | 4.9 | 22 |
| 406 | 17 | SURG | MYELOPROLIF DISORD OR POORLY DIFF NEOPLASM W MAJ O.R.PROC & C.C. | 2.5307 | 16.8 | 12.9 | 30 |
| 407 | 17 | SURG | MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O C.C. | 1.7127 | 13.0 | 9.6 | 26 |
| 408 | 17 | SURG | MYELOPROLIF DISORD OR POORLY DIFF NEOPL WITH OTHER O.R.PROC | 1.0502 | 8.3 | 5.3 | 22 |
| 409 | 17 | MED | RADIOTHERAPY | .9856 | 10.9 | 7.0 | 24 |
| 410 | 17 | MED | CHEMOTHERAPY | .4285 | 3.1 | 2.4 | 9 |
| 411 | 17 | MED | HISTORY OF MALIGNANCY W/O ENDOSCOPY | .5907 | 5.9 | 3.8 | 21 |
| 412 | 17 | MED | HISTORY OF MALIGNANCY WITH ENDOSCOPY | .3389 | 2.4 | 1.9 | 6 |
| 413 | 17 | MED | OTHR MYELOPROLIF DISORD OR POORLY DIFF NEOPL Dx AGE>69 +/OR C.C | 1.0457 | 10.7 | 6.9 | 24 |
| 414 | 17 | MED | OTHR MYELOPROLIF DISORD OR POORLY DIFF NEOPL Dx AGE<70 W/O C.C. | .8984 | 9.2 | 5.4 | 22 |
| 415 | 18 | SURG | O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES | 3.3292 | 20.5 | 14.7 | 32 |
| 416 | 18 | MED | SEPTICEMIA AGE >17 | 1.6183 | 11.7 | 8.3 | 25 |
| 417 | 18 | MED | SEPTICEMIA AGE 0-17 | 1.1532 | 7.6 | 5.4 | 22 |
| 418 | 18 | MED | POSTOPERATIVE & POST-TRAUMATIC INFECTIONS | 1.0026 | 9.8 | 7.5 | 25 |
| 419 | 18 | MED | FEVER OF UNKNOWN ORIGIN AGE >69 AND/OR C.C. | .9306 | 8.4 | 6.1 | 23 |
| 420 | 18 | MED | FEVER OF UNKNOWN ORIGIN AGE 18-69 W/O C.C. | .8319 | 7.5 | 5.5 | 23 |

* MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.
** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.
NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER CASES.
NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.
NOTE: ARITHMETIC MEAN INCLUDED FOR COMPARATIVE PURPOSES. IT IS NOT USED FOR PAYMENT.

TABLE 5

LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, ARITHMETIC AND GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

| DRG | MDC | | TITLE | RELATIVE WEIGHTS | ARITHMETIC MEAN LOS | GEOMETRIC MEAN LOS | OUTLIER THRESHOLD |
|---|---|---|---|---|---|---|---|
| 421 | 18 | MED | VIRAL ILLNESS AGE >17 | .5674 | 5.8 | 4.6 | 16 |
| 422 | 18 | MED | VIRAL ILLNESS + FEVER OF UNKNOWN ORIGIN AGE 0-17 | .6582 | 5.2 | 3.6 | 18 |
| 423 | 18 | MED | OTHER INFECTIOUS + PARASITIC DISEASES DIAGNOSES | 1.3207 | 11.0 | 8.0 | 25 |
| 424 | 19 | SURG | O.R. PROCEDURES WITH PRINCIPAL DIAGNOSIS OF MENTAL ILLNESS | 2.2112 | 22.1 | 15.0 | 32 |
| 425 | 19 | MED | ACUTE ADJUST REACT + DISTURBANCES OF PSYCHOSOCIAL DYSFUNCTION | .6097 | 7.6 | 4.8 | 22 |
| 426 | 19 | MED | DEPRESSIVE NEUROSES | .8330 | 11.8 | 7.8 | 25 |
| 427 | 19 | MED | NEUROSES EXCEPT DEPRESSIVE | .7019 | 9.8 | 6.4 | 23 |
| 428 | 19 | MED | DISORDERS OF PERSONALITY + IMPULSE CONTROL | .8513 | 11.9 | 7.4 | 24 |
| 429 | 19 | MED | ORGANIC DISTURBANCES + MENTAL RETARDATION | .8424 | 11.0 | 7.6 | 25 |
| 430 | 19 | MED | PSYCHOSES | 1.0762 | 15.5 | 10.5 | 28 |
| 431 | 19 | MED | CHILDHOOD MENTAL DISORDERS | .8495 | 10.4 | 6.6 | 24 |
| 432 | 19 | MED | OTHER DIAGNOSES OF MENTAL DISORDERS | .6969 | 8.1 | 4.9 | 22 |
| 433 | 20 | | SUBSTANCE USE AND INDUCED ORGANIC MENTAL DISORDERS, LEFT AMA | .3906 | 4.4 | 2.9 | 16 |
| 434 | 20 | | SUBST ABUSE,INTOX INDUCE MNTL SYN EXC DEPEND & OR OTH SYMPT TRT | .7098 | 8.2 | 5.4 | 22 |
| 435 | 20 | | SUBSTANCE DEPENDENCE, DETOX AND/OR OTHER SYMPTOMATIC TREATMENT | .7980 | 10.2 | 6.7 | 24 |
| 436 | 20 | | SUBSTANCE DEPENDENCE WITH REHABILITATION THERAPY | 1.0166 | 14.2 | 9.8 | 27 |
| 437 | 20 | | SUBSTANCE DEPENDENCE, COMBINED REHABILITATION AND DETOX THERAPY | 1.3276 | 19.0 | 14.6 | 32 |
| 438 | | | NO LONGER VALID | .0000 | | | |
| 439 | 21 | SURG | SKIN GRAFTS FOR INJURIES | 1.7930 | 15.4 | 9.0 | 26 |
| 440 | 21 | SURG | WOUND DEBRIDEMENTS FOR INJURIES | 2.0315 | 15.8 | 9.3 | 26 |
| 441 | 21 | SURG | HAND PROCEDURES FOR INJURIES | .7305 | 4.6 | 2.7 | 16 |
| 442 | 21 | SURG | OTHER O.R. PROCEDURES FOR INJURIES AGE >69 AND/OR C.C. | 1.8156 | 10.5 | 6.1 | 23 |
| 443 | 21 | SURG | OTHER O.R. PROCEDURES FOR INJURIES AGE <70 W/O C.C. | 1.4872 | 9.4 | 5.6 | 23 |
| 444 | 21 | MED | MULTIPLE TRAUMA AGE >69 AND/OR C.C. | .7074 | 7.7 | 5.4 | 22 |
| 445 | 21 | MED | MULTIPLE TRAUMA AGE 18-69 W/O C.C. | .6015 | 6.2 | 4.1 | 21 |
| 446 | 21 | MED | * MULTIPLE TRAUMA AGE 0-17 | .4796 | | 2.4 | 10 |
| 447 | 21 | MED | ALLERGIC REACTIONS AGE >17 | .4471 | 4.1 | 2.9 | 14 |
| 448 | 21 | MED | * ALLERGIC REACTIONS AGE 0-17 | .3470 | | 2.9 | 9 |
| 449 | 21 | MED | POISONING AND TOXIC EFFECTS OF DRUGS AGE >69 AND/OR C.C. | .6954 | 6.5 | 4.7 | 22 |
| 450 | 21 | MED | POISONING AND TOXIC EFFECTS OF DRUGS AGE 18-69 W/O C.C. | .5422 | 5.1 | 3.3 | 18 |
| 451 | 21 | MED | POISONING AND TOXIC EFFECTS OF DRUGS AGE 0-17 | .5498 | 5.0 | 3.4 | 20 |
| 452 | 21 | MED | COMPLICATIONS OF TREATMENT AGE >69 AND/OR C.C. | .8080 | 7.0 | 4.7 | 22 |
| 453 | 21 | MED | COMPLICATIONS OF TREATMENT AGE <70 W/O C.C. | .7505 | 6.5 | 4.3 | 21 |
| 454 | 21 | MED | OTHER INJURIES, POISONINGS + TOXIC EFF DIAG AGE >69 AND/OR C.C. | .8098 | 7.5 | 4.6 | 22 |
| 455 | 21 | MED | OTHER INJURIES, POISONINGS + TOXIC EFF DIAG AGE <70 W/O C.C. | .6003 | 6.0 | 3.5 | 21 |

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** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.
NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER CASES.
NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.
NOTE: ARITHMETIC MEAN INCLUDED FOR COMPARATIVE PURPOSES. IT IS NOT USED FOR PAYMENT.

LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, ARITHMETIC AND GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

| DRG | MDC | | TITLE | RELATIVE WEIGHTS | ARITHMETIC MEAN LOS | GEOMETRIC MEAN LOS | OUTLIER THRESHOLD |
|---|---|---|---|---|---|---|---|
| 456 | 22 | | BURNS, TRANSFERRED TO ANOTHER ACUTE CARE FACILITY | 1.8156 | 11.9 | 5.5 | 23 |
| 457 | 22 | | EXTENSIVE BURNS | 7.5688 | 22.0 | 8.8 | 26 |
| 458 | 22 | SURG | NON-EXTENSIVE BURNS WITH SKIN GRAFTS | 3.9455 | 26.0 | 18.9 | 36 |
| 459 | 22 | SURG | NON-EXTENSIVE BURNS WITH WOUND DEBRIDEMENT + OTHER O.R. PROC | 3.2662 | 20.8 | 13.5 | 31 |
| 460 | 22 | MED | NON-EXTENSIVE BURNS W/O O.R. PROCEDURE | 1.1595 | 11.2 | 7.5 | 25 |
| 461 | 23 | SURG | O.R. PROC WITH DIAGNOSES OF OTHER CONTACT WITH HEALTH SERVICES | 1.3572 | 10.2 | 5.3 | 22 |
| 462 | 23 | MED | REHABILITATION | 2.1408 | 24.2 | 18.0 | 35 |
| 463 | 23 | MED | SIGNS + SYMPTOMS WITH C.C. | .7951 | 8.0 | 5.9 | 23 |
| 464 | 23 | MED | SIGNS + SYMPTOMS W/O C.C. | .6948 | 7.8 | 5.0 | 22 |
| 465 | 23 | MED | AFTERCARE WITH HISTORY OF MALIGNANCY AS SECONDARY DX | .2882 | 2.1 | 1.7 | 5 |
| 466 | 23 | MED | AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DX | .4153 | 4.5 | 2.7 | 16 |
| 467 | 23 | MED | OTHER FACTORS INFLUENCING HEALTH STATUS | .7223 | 7.9 | 3.9 | 21 |
| 468 | | | UNRELATED OR PROCEDURE | 2.4542 | 17.1 | 11.7 | 29 |
| 469 | | ** | PDX INVALID AS DISCHARGE DIAGNOSIS | .0000 | | .0 | 0 |
| 470 | | ** | UNGROUPABLE | .0000 | | .0 | 0 |
| 471 | 8 | SURG | BILATERAL OR MULTIPLE MAJOR JOINT PROCEDURES OF THE LOWER EXTREMI | 3.8994 | 23.5 | 20.9 | 36 |

* MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.
** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.
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NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.
NOTE: ARITHMETIC MEAN INCLUDED FOR COMPARATIVE PURPOSES. IT IS NOT USED FOR PAYMENT.

TABLE 6 - CHANGES TO GROUPER PROGRAM

| PROBLEM | GROUPER MODIFICATION |
|---|---|
| A. DRG LOGIC ISSUES | |
| 1. In MDC 5 (Diseases and Disorders of the Circulatory System), GROUPER assigns a patient who has had a toe or upper limb amputation to DRG 114 (Upper Limb and Toe Amputation for Circ. Sys. Disorders). If this same patient also has a leg amputated during the same hospital episode, the patient is still assigned to DRG 114, rather than to DRG 113(Amputations for Circ. Sys. Disorders Except Upper Limb and Toe). | Assign a patient to DRG 114 if only a toe or upper limb has been amputated. If the patient also had a leg amputation or any amputation of the lower extremity for circulatory disorders other than a toe, the assignment is DRG 113. |
| 2. In MDC 9 (Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast), GROUPER assigns a patient who does not have a principal diagnosis of malignancy and who has had an open breast biopsy to DRG 262 (Breast Biopsy and Local Excision for Non-malignancy). If the patient also has, for example, a unilateral simple mastectomy during the same hospital episode, the patient is still assigned to DRG 262 rather than DRG 261 (Breast Proc. for Non-malignancy Except Biopsy and Loc. Excision). | Change the initial search from "Principal Diagnosis of Malignancy" to "Any Diagnosis of Malignancy" and assign those patients who do not have any diagnosis of a breast malignancy and who have a biopsy and local excision only to DRG 262. If the patient also has a breast procedure for nonmalignancy other than a biopsy or local excision, the assignment is DRG 261. |
| 3. Most of the congenital anomaly diagnosis codes are included in the MDC associated with the organ system affected. There are, however, four congenital anomaly codes in MDC 15 (Newborns and Neonates with Conditions Originating in the Perinatal Period) that would be more appropriately included in another MDC as they are not solely used as newborn or neonate diagnoses. | Move diagnosis code 7583 (Autosmal Deletion Snyd.) to MDC 19 (Mental Diseases and Disorders); DRG 429 (Organic Disturbances and Mental Retardation).<br><br>Move diagnosis code 7584 (Balance Autosom. Transloc.) and diagnosis code 7585 (Autosomal Anomolies NEC) to MDC 23 (Factors Influencing Health Status and Other Contacts With Health Services); DRG 467 (Other Factors Influencing Health Status).<br><br>Move diagnosis code 7586 (Gonadal Dsygenesis) to MDC 12 (Diseases and Disorders of the Male Reproductive System); DRG 352 (Other Male Reproductive System Diagnoses); and MDC 13 (Diseases and Disorders of the Female Reproduction System); DRG 369 (Menstrual and Other Female Reproductive System Disorders). The MDC assignment is dependent on the sex of the patient. |
| 4. MDC 17 (Myeloproliferative Diseases and Disorders, Poorly Differentiated Neoplasms) differs from all other MDCs with a surgical hierarchy because patients with O.R. procedures are, in some cases, assigned to medical DRGs. That is, patients who had selected O.R. procedures are assigned to certain DRGs and patients who had an O.R. procedure not in the selected list are assigned to the medical DRGs (403-405, 409-414). | Assign patients who have any surgical procedure, other than those listed as major procedures (DRGs 400, 406, and 407), in MDC 17 to DRGs 401, 402, and 408, rather than to the medical DRGs. Consequently, the titles of DRGs 401, 402, and 408 are revised by changing the phrase "Minor O.R. Procedures" to "Other O.R. Procedures." |

TABLE 6 - CHANGES TO GROUPER PROGRAM

| PROBLEM | GROUPER MODIFICATION |
|---|---|
| 5. DRG 243 (Medical Back Problems) includes diagnosis codes for all type of back pain except code 7241 (Pain in Thoracic Spine), which is assigned to DRG 247 (Signs and Symptoms of Musculoskeletal System and Connective Tissues). | Add diagnosis code 7241 to DRG 243 and remove it from DRG 247. |
| 6. DRG 108 and DRG 109 include cardiothoracic procedures. The distinction is that procedures in DRG 108 (Cardiothoracic Proc., Except Valve and Coronary Bypass, with Pump) are performed with a heart pump and procedures in DRG 109 (Cardiothoracic Procedures Without Pump) are performed without a heart pump. Currently, however, not all procedures in DRG 108 always require the use of a heart pump and procedures in DRG 109 are not always performed without a heart pump. | Combine the O.R. procedures in DRG 108 and DRG 109. The presence of procedure code 3961 (Extracoporeal Circulation) determines whether or not a heart pump was used. If code 3961 is present on the record, assign the patient to DRG 108; if code 3961 is not present, assign to DRG 109. |
| *7a. Procedure code 36.0 (Remove Coronary Artery Obstruction) is now used almost exclusively to code percutaneous transluminal coronary angioplasty. Code 36.0 is currently assigned to DRG 108 (Cardiothoracic Proc., Except Valve and Coronary Bypass, With Pump), which is considered to be major cardiac surgery with heart pump. Percutaneous transluminal coronary angioplasty is not done with heart pump. However, the open procedure on the coronary artery requiring the use of a heart-lung machine should remain in DRG 108 using the identifying codes combination of 36.0 plus 39.61 (Extracorporal Circulation). The use of resources for these patients is similar to the other patients classified in DRG 108. | a. Move procedure code 36.0 to DRG 112 (Vascular Procedures Except Major Reconstruction). However,if procedure code 36.0 is used in combination with 3961, it is still assigned to DRG 108. |
| b. Some procedures in DRGs 110 and 111 (Major Reconstructive Vascular Procedures) and DRG 112 (Vascular Procedures Except Major Reconstruction) are performed with a heart pump. | b. If patients currently assigned to DRGs 110, 111 and 112 have procedure code 39.61 present, assign them to DRG 108. |
| *8a. Presently, diagnosis code 7746 (Fetal/Neonatal Jaundice, NOS) is on the list of complications and comorbidities (CC). It is also listed in MDC 15 (Newborns and Other Neonates With Conditions Originating in the Perinatal Period); DRG 391 (Normal Newborns) as an incidental problem. | Remove code 7746 from the list of CCs and continue to treat it as an incidental problem for DRG 391. |
| b. In the past, there have been problems with the assignment of patients to DRG 391 (Normal Newborns) in MDC 15. | A patient is assigned to DRG 391 if the principal diagnosis is from the following list: |

| | |
|---|---|
| V300 Single liveborn-in hosp | V360 Multiple nb/sb-in hosp |
| V301 Singl livebrn-before adm | V361 Mult nb/sb-before adm |
| V310 Twin, mate lb-in hosp | V370 Mult birth NOS-in hosp |
| V311 Twin, mate lb-before adm | V371 Mult brth NOS-before adm |
| V320 Twin, mate sb-in hosp | V390 Liveborn NOS-in hosp |
| V321 Twin, mate sb-before adm | V391 Liveborn NOS-before adm |
| V330 Twin NOS-in hospital | 7624 Prolapsed cord aff nb |
| V331 Twin NOS-before admissn | 7625 Oth umbil cord compress |
| V340 Oth multiple nb-in hosp | 7626 Umbil cord NEC aff nb |
| V341 Oth mult nb-before adm | 7630 Breech del/extrac aff nb |
| V350 Oth multiple sb-in hosp | 7631 Malpos/dispro NEC aff nb |
| V351 Oth mult sb-before adm | 7632 Forceps delivery aff nb |

TABLE 6 - CHANGES TO GROUPER PROGRAM

| PROBLEM | GROUPER MODIFICATION |
|---|---|
| | 7633 Vacuum extrac del aff nb<br>7636 Precipitate del aff nb<br>7639 Compl deliv NOS aff nb<br>7660 Exceptionally large baby<br>7661 Heavy-for-date infan NEC<br>7662 Post-term infant NOS<br>7671 Scalp injury at birth<br>7686 Mild/mod birth asphyxia<br>7746 Fetal/neonatal jaund NOS<br>7788 Nb integument cond NEC<br><br>A patient is assigned to DRG 391, if there is a principal diagnosis from the list above and there is no secondary diagnosis or all secondary diagnoses are from the following:<br><br>V300 Single liveborn-in hosp<br>V301 Singl livebrn-before adm<br>V310 Twin, mate lb-in hosp<br>V311 Twin, mate lb-before adm<br>V320 Twin, mate sb-in hosp<br>V321 Twin, mate sb-before adm<br>V330 Twin NOS-in hosp<br>V331 Twin NOS-before admissn<br>V340 Oth multiple nb-in hosp<br>V341 Oth mult nb-before adm<br>V350 Oth multiple sb-in hosp<br>V351 Oth mult sb-before adm<br>V360 Multiple nb/sb-in hosp<br>V361 Mult nb/sb-before adm<br>V370 Mult birth NOS-in hosp<br>V371 Mult brth NOS-before adm<br>V390 Liveborn NOS-in hosp<br>V391 Liveborn NOS-before adm<br>V502 Routine circumcision<br>V703 Med exam NEC-admin purposes<br>V773 Screen-phenylketonuria<br>605 Redun prepuce phimosis<br>6869 Local skin infection NOS<br>6910 Diaper or napkin rash<br>7624 Prolapsed cord aff nb<br>7625 Oth umbil cord compress<br>7626 Umbil cord NEC aff nb<br>7630 Breach del/extrac aff nb<br>7631 Malpos/dispro NEC aff nb<br>7632 Forceps delivery aff nb<br>7633 Vacuum extrac del aff nb<br>7636 Precipitate del aff nb<br>7639 Compl deliv NOS aff nb<br>7660 Exceptionally large baby<br>7661 Heavy-for-date infan NEC<br>7662 Post-term infant NOS<br>7671 Scalp injury at birth<br>7686 Mild/mod birth asphyxia<br>7746 Fetal/neonatal jaund NOS<br>7788 Nb integument cond NEC<br><br>Therefore, the branching criteria on the tree diagram in MDC 15 changes from "Normal Newborns Without Significant Secondary Diagnosis" to "Normal Newborns Without Any Significant Complicating Diagnosis." |
| 9. Diagnosis codes 1946 (Malig. Neopl. Paraganglia NEC), 2276 (Benign neopl. paraganglia), and 2373 (Unc. Behav. Neo. Paragang.) are in MDC 10 (Endocrine, Nutritional and Metabolic Diseases and Disorders) while other related diagnoses are in MDC 1 (Diseases and Disorders of the Nervous System). | Add diagnosis codes 1946, 2276, and 2373 to MDC 1 (DRGs 10 and 11) and remove from MDC 10. |
| 10. Diagnosis code 9968 (Complication Transplanted Organ) is assigned to MDC 21 (Injury, Poisoning and Toxic Effects of Drugs). Since this code relates to any transplanted organ, it cannot be assigned to an organ specific MDC. Currently, codes 5051 (Ancillary Liver Transplant) and 5059 (Liver Transplant) are allowed with MDC 21 and assigned to DRG 442 and DRG 443 (Other O.R. Procedures for Injuries). Payment for these DRGs is inadequate for the procedure. All other transplant procedures associated with rejected organs are grouped to DRG 468. | Remove procedure codes 5051 and 5059 from MDC 21 (DRG 442 and DRG 443) and allow assignment to DRG 468. |

TABLE 6 – CHANGES TO GROUPER PROGRAM

| PROBLEM | GROUPER MODIFICATION |
|---|---|
| 11. Procedure code 5494 (Create Peritoneal Vascular Shunt) is a major shunt procedure, yet it is DRG 201 (Other Hepatobiliary or Pancreas O.R. Procedures) and not in DRG 191 (Major Pancreas, Liver and Shunt Procedures). | Add procedure code 5494 to DRG 191 and remove it from DRG 201. |
| 12. Diagnosis code 4565 (Pelvic Varices) is assigned only to MDC 13 (Diseases and Disorders of the Female Reproductive System. This diagnosis code is also applicable to MDC 12 (Diseases and Disorders of the Male Reproductive System). | Add diagnosis code 4565 (Pelvic Varices) to MDC 12, DRG 352 (Other Male Reproductive System Diagnoses). |
| 13. Procedure code 031 (Division Intraspinal Nerve Root) is applicable to neck and back procedures and therefore should also be assigned to MDC 8 (Disease and Disorder of the Musculosketetal Sep. and Connective Ties.) | Add procedure code 031 (Division Intraspinal Nerve Root) to MDC 8, DRGS 214 and 215 (Back and Neck Procedures). |
| 14. DRG 209 (Major Joint Procedures) does not adequately distinguish multiple joint procedures from single joint procedures. | Create DRG 471 (Bilateral or Multiple Major Joint Procedures of the Lower Extremity) to include any combination of two or more of the following procedure codes: 8141, 8148, 8151, 8159, 8161, 8162, 8163, and 8164. |
| 15. DRGs 434 through 438 do not adequately reflect substance dependence detoxification and rehabilitation treatment. | Revise DRGs 434 through 438 as follows:<br>Move all diagnosis codes in DRGs 435, 437, and 438 (except diagnosis codes 2910, 2913, 2918, 2919, 2920, 30300, 30301, 30302, 30303, and 30390) to DRG 434 (Substance Abuse, Intoxication, or Induced Mental Syndrome Except Dependence). Move all diagnosis codes in DRGs 434 and 436 and diagnosis codes 2910, 2920, 30300, 30301, 30302, 30303, and 30390 to DRGs 435, 436, and 437.<br>Move diagnosis codes 2913, 2918, and 2919 to DRG 435.<br>Diagnosis procedure code V57.89 must be present for a case to be assigned to DRG 436. Diagnosis procedure codes V57.89 and 94.25 must be present for a case to be assigned to DRG 437.<br>Delete DRG 438. |
| *16. Patients with a principal diagnosis of diabetes mellitus with manifestations in an organ system other than the endocrine system (that is, renal circulatory, or neurologic) currently group to DRG 468 (Unrelated O.R. Procedure) when they undergo a procedure that is properly assigned to the MDC of the organ system that is affected. | Move "diabetes with manifestation of ..." codes to the MDC for the manifestation as follows:<br>a. Move diabetes with renal manifestations (250.40 and 250.41) from DRGs 294 and 295 in MDC 10 to DRGs 331, 332, and 333 in MDC 11. For example, if the diagnosis of 250.40 or 250.41 and procedure 55.69 (Kidney Transplant), the case will group to DRG 302.<br>b. Move diabetes with neurological manifestations (250.60 and 250.61) from DRGs 294 and 295 in MDC 10 to DRGs 18 and 19 in MDC 1. Move diabetes with circulatory manifestations (250.70 and 250.71) from DRGs 294 and 295 in MDC 10 to DRGs 130 and 131 in MDC 5.<br>c. Diabetes with ophthalmic manifestations (250.50 and 250.51) is already in MDC 2. |

TABLE 6 - CHANGES TO GROUPER PROGRAM

| PROBLEM | GROUPER MODIFICATION |
|---|---|
| **17. Procedure Code 57.33 (Transurethral biopsy of bladder) should be added as a valid code for MDC 12- Diseases and Disorders of the Male Reproductive System and MDC-13 Diseases and Disorders of the Female Reproductive System. | Add procedure code 57.33 to MDC 12, DRGs 344 and 345 (Other Male Reproductive System O.R. Procedures) and also to MDC 13-Diseases and Disorders of the Female Reproductive System, DRG 365 (Other Female Reproductive System O.R. Procedures). Procedure code 57.33 remains in its current assignment, DRGs 310 and 311 (Transurethral Procedures), as well. |
| **18. Since code 724.1 (Pain in Thoracic Spine) will be transferred from DRG 247 to DRG 243, in order to consistently classify all back symptoms to the same DRG, it is recommended that code 724.8 (Other unspecified back disorders) also be transferred from DRG 247 to DRG 243. | Add diagnosis code 724.8 to DRG 243 (Medical Back Problems) and remove from DRG 247 (Signs and Symptoms of Musc Sys. and Conn. Tissue.) |
| **19. Procedure 77.28 (wedge osteotomy of tarsals and metatarsals) done for Keratoderma plantaris improperly codes to DRG 468. This procedure appears in DRG 225 (Foot Procedures) but it should also be listed in DRGs 269 and 270 (Other Skin Subcutaneous Tissue and Breast O.R. Procedures). | Add procedure code 77.28 to MDC 9 (Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast), DRGs 269 and 270. |
| **20. Procedure codes 6952 (Aspiration curettage following delivery or abortion) and 7491 (Hysterotomy to terminate pregnancy) are not delivery codes. Therefore, they should not be in DRG 375 (Vaginal Delivery with O.R. Procedure Except Sterilization and/or D&C). These codes should be added to DRG 381 (Abortion with D&C). Correspondingly, aspiration curettage is considered to be a procedure generally performed in the operating room. | Add procedure codes 6952 and 7491 to DRG 381 (Abortion with D&C) and remove procedure code 7491 from DRG 375. Also add 6952 to the list of O.R. Procedures. |
| **21. If performed, an appendectomy procedure is an incidental procedure for DRG 365 (Other Female Reproductive Sys O.R. Procedures). | Remove procedure code 470 (Appendectomy) from DRG 365 and replace it with procedure code 471 (Incidental Appendectomy). |
| **22. The diagnosis code 228.1 (Lymphangiona, any site) should be classified in MDC 16 (Diseases and Disorders of the Blood and Blood Forming Organs and Immunological Disorders) and not in its current MDC 5 (Circulatory System) assignment. This was an inadvertent misclassification made during the original DRG classification process. | Move diagnosis code 228.1 to DRGs 398 and 399 (Reticuloendothelial and Immunity Disorders) and remove it from MDC 5. |

TABLE 6 - CHANGES TO GROUPER PROGRAM

| PROBLEM | GROUPER MODIFICATION |
|---|---|
| B. OPERATING ROOM vs NON-OPERATING ROOM ASSIGNMENT | |
| 1. Procedure code 3786 (Remove Cardiac Pacemaker) is used for the removal of both a temporary pacemaker and a permanent pacemaker. Presently, this code appears on the list of operating room procedures and, when coded, results in assignment to one of the operative pacemaker DRGs. In general, the removal of a temporary pacemaker is not performed in the operating room. If a permanent pacemaker is removed, then usually a replacement pacemaker is inserted. In that case, the reinsertion is coded and the patient is assigned to the appropriate DRG.<br><br>The current operating room procedures, listed below, are also considered to be procedures not generally performed in the operating room.<br><br>8623 (Removal of nail)<br>5499 (Abdomen region operation, NEC)<br>3996 (Total body perfusion)<br>5196 Percutaneous Extraction of common duct stones) | Remove codes 3786, 8623, 5499, 3996, and 5196 from the list of operating room procedures and from the DRGs to which they are currently assigned. |
| 2. Procedure codes 6813 (Uterine Biopsy) and 7076 (Hymenorrhaphy) are generally performed in an operating room and therefore should be assigned to the list of O.R. procedures. | Add procedure codes 6813 (Uterine biopsy) and 7076 (Hymenorrhaphy) to the list of O.R. procedures and to MDC 13, DRG 360 (Vagina, cervix and vulva procedures). |
| **3. Procedure code 3961 (Extracorporeal circulation) is performed in conjunction with another operating procedure, and is not generally considered the only procedure performed. | Remove procedure code 3961 from the list of O.R. procedures. |
| C. COMPLICATION AND COMORBIDITY MEMBERSHIP | |
| *1. A number of diagnostic codes should be added to the list of complications and comorbidities. | Add the following diagnosis codes to the list of complications and comorbidities:<br>25090 Diab w compl NOS adult<br>25091 Diab w compl NOS juven<br>64820 Anemia compl preg<br>64821 Anemia - delivered<br>64822 Anemia - delivered w P/P<br>64823 Anemia - antepartum<br>64824 Anemia - postpartum<br>87272 Open wnd ossicles-comp<br>87273 Open wnd eustach tb-comp<br>87274 Open wound cochlea-comp<br>87333 Open wnd nas sinus-compl<br>8743 Open wound thyroid-compl<br>8745 Open wound pharynx-compl<br>8870 Amput below elb, unilat<br>8871 Amp below elb, unil-comp<br>8872 Amput abv elbow, unilat<br>8873 Amput abv elb, unil-comp<br>8874 Amputat arm, unilat NOS<br>8875 Amputat arm, unil NOS-comp<br>8876 Amputation arm, bilat<br>8877 Amputat arm, bilat-compl<br>8960 Amputation foot, unilat<br>8961 Amput foot, unilat-compl<br>8962 Amput foot, bilat<br>8963 Amputat foot, bilat-comp<br>8970 Amput below knee, unilat<br>8971 Amputat bk, unilat-compl<br>8972 Amput above knee, unilat<br>8973 Amput abv kn, unil-compl<br>8974 Amputat leg, unilat NOS<br>8975 Amput leg, unil NOS-comp<br>8976 Amputation leg, bilat<br>8977 Amputat leg, bilat-compl |
| **2. Diagnosis transient hypertension of pregnancy-unspecified (code 64230) and transient hypertension of pregnancy - antepartum (code 64233) are not significant antepartum complications. | Remove diagnosis codes 64230 and 64233 from the list of medical complications for DRG 383 (Other Antepartum Diag with Medical Complications). |

TABLE 6 - CHANGES TO GROUPER PROGRAM

| PROBLEM | GROUPER MODIFICATION |
|---|---|
| D. SURGICAL HIERARCHY AND WEIGHT ISSUES<br>1. When a cataract operation is performed, the patient is assigned to DRG 39 (Lens Procedure). If a vitrectomy or anterior chamber injection or evacuation is performed during the cataract operation, and coded accordingly, the patient is assigned to DRG 42 (Intraocular Procedures Except Retina, Iris and Lens). This is because vitrectomies and anterior chamber procedures are higher than lens procedures in the surgical hierarchy. However, the process of removing a small amount of vitreous or an injection or evacuation from the anterior chamber during a cataract operation is incidental to the lens extraction and the DRG assignment, therefore, should be for the lens extraction, not for the higher weighted vitrectomy or anterior chamber. | If a lens procedure only or a lens procedure and one of the following procedures is performed, assign to DRG 39.<br>1291 Therapeut Evac Ant Chamber)<br>1292 Anterior Chamber Inject.<br>1471 Anterior Removal Vitreous<br>1472 Vitreous Removal NEC<br>1473 Anterior Mechan Vitrect.<br>1474 Mechan Vitrectomy<br>1475 Vitreous Substitut Inject.<br>1479 Vitreous Operation NEC<br><br>If any of the procedures listed above are performed without a lens procedure, assign to DRG 42. |
| 2. There has been concern regarding the DRG surgical hierarchy in MDC 6 (Diseases and Disorders of the Digestive System). The position of Peritoneal Adhesiolysis, DRG 150-151, in relation to Minor Small and Large Bowel Procedures, DRG 152-153, and Hernia Procedures, DRG 159-163 is of particular concern. Analysis of HCFA average LOS and average charge data for the surgical DRGs in MDC 6 supports modification of the surgical hierarchy for MDC 6. | Change MDC 6 surgical hierarchy as follows:<br>MDC 6-Diseases and Disorders of the Digestive System<br>DRG 146-147 Rectal Resection<br>DRG 148-149 Major Small and Large Bowel Procedures<br>DRG 154-156 Stomach, Esophageal and Duodenal Procedures<br>DRG 150-151 Peritoneal Adhesiolysis<br>DRG 152-153 Minor Small and Large Bowel Procedures<br>DRG 164-167 Appendectomy<br>DRG 159-163 Hernia Procedures<br>DRG 157-158 Anal Procedures<br>DRG 168-169 Procedures in the Mouth<br>DRG 170-171 Other Digestive System O.R. Procedures |
| **3. Analysis of HCFA average LOS and average charge data supports modification of the following MDCs: | |
| MDC 8 (Diseases and Disorders of the Musculoskeletal and Connective Tissues) wound debridement should be placed above amputations. | a. Place wound debridement above amputation in the surgical hierarchy for MDC 8. |
| MDC 9 (Diseases and Disorders of the Skin and Subcutaneous Systems) skin grafts should be placed above breast procedures. | b. Place skin grafts above breast procedures in the surgical hierarchy for MDC 9. |
| MDC 12 (Diseases and Disorders of the Male Reproductive System) penis procedures should be placed above transurethral resections. | c. Place penis procedures above transurethral prostatectomy in the surgical hierarchy for MDC 12. |
| **4. New DRG 471 (Bilateral or Multiple Joint Procedures of the Lower Extremity) should be included only in MDC 8 - Diseases and Disorders of the Musculoskeletal System, and should acquire the first position in the surgical hierarchy for MDC 8, before Major Joint and Limb Reattachment Procedures. | DRG 471 is to be included in MDC 8 only and acquires the first position in the surgical hierarchy for the MDC. |

TABLE 6 - CHANGES TO GROUPER PROGRAM

| PROBLEM | GROUPER MODIFICATION |
|---|---|
| *E. DRG 468<br>Patients are assigned to DRG 468 (Unrelated O.R. Procedure) when all the operating room procedures are unrelated to the MDC of the patients' principal diagnosis. There appears to be a need to update certain DRGs by including O.R. procedures that could possibly be performed for diagnoses within the MDC, so patients would no longer be assigned to DRG 468. | Add the following list of O.R. procedures, listed by MDC, to the DRG specified:<br>MDC 01 - Diseases and Disorders of the Nervous System<br>DRG 4 (Spinal procedures)<br>7781 Oth chest cage ostectomy<br>7791 Tot chest cage ostectomy<br>DRG 5 (Extracranial vascular procedures)<br>3832 Head/neck ves resec-anas<br>3929 Vasc shunt and bypass NEC<br>3930 Suture of vessel NOS<br>3931 Suture of artery<br>3932 Suture of vein<br>3956 Repair vess w tis patch<br>3957 Rep vess w synth patch<br>3958 Repair vess w patch NOS<br>3959 Repair of vessel NEC<br>398 Vascular body operations<br>3992 Vein inject-scleros agnt<br>DRGs 7 and 8 (Peripheral and cranial nerve and other nervous sys. procs.)<br>0719 Endocrine dx proc NEC<br>0780 Thymectomy NOS<br>0781 Part excision of thymus<br>0782 Total excision of thymus<br>0851 Canthotomy<br>0852 Blepharorrhaphy<br>0859 Adjust lid position NEC<br>8131 Foot arthroplas w prosth<br>8139 Foot/toe arthroplast NEC<br>8171 Hand arthroplas w prosth<br>8179 Hand arthroplasty NEC<br>8186 Carpal arthropl-syn pros<br>8187 Wrist arthroplasty NEC<br>8313 Other tenotomy<br>8314 Fasciotomy<br>8319 Soft tissue division NEC<br>8321 Soft tissue biopsy<br>8341 Tendon excision for grft<br>8343 Musc/fasc excis for grft<br>8345 Other myectomy<br>8349 Other soft tissue excis<br>8681 Repair facial weakness<br>MDC 02 - Diseases and Disorders of the Eye<br>DRG 37 (Orbital procedures)<br>7679 Open reduct face fx NEC<br>7691 Bone graft to face bone<br>7692 Syn implant to face bone<br>7646 Facial bone reconstr NEC<br>DRG 38 (Primary iris procedures)<br>1273 Cyclophotocoagulation<br>DRG 39 (Lens Procedures)<br>1301 Removal of foreign body from lens with magnet |

TABLE 6 - CHANGES TO GROUPER PROGRAM

| PROBLEM | GROUPER MODIFICATION |
|---|---|
| | DRGs 40 and DRG 41 (Extraocular procedures except orbit) |
| | 864 Radical excis skin les |
| | MDC 03 - Diseases and Disorders of the Ear, Nose and Throat |
| | DRG 55 (Miscellaneous ear, nose and throat procs.) |
| | 0609 Incis thyroid field NEC |
| | 0912 Lacrimal sac biopsy |
| | 0919 Lacrimal sys dx proc NEC |
| | 0981 Dacryocystorhinostomy |
| | 0999 Lacrimal system op NEC |
| | DRG 63 (Other ear, nose and throat O.R. procs.) |
| | 0474 Periph nerv anastom NEC |
| | 0475 Postop revis per nerv op |
| | 0476 Late repair per nerve inj |
| | 1652 Orbit exent w bone remov |
| | 1665 2ndry exent cavity graft |
| | 1666 Revis exenter cavity NEC |
| | 1698 Operation on orbit NEC |
| | 7779 Excise bone for gft NEC |
| | MDC 04 - Diseases and Disorders of the Respiratory System |
| | DRGs 76 and 77 (O.R. proc. on the resp. sys. except major chest with O.R.) |
| | 5012 Liver biopsy NEC |
| | 8321 Soft tissue biopsy |
| | MDC 05 - Diseases and Disorders of the Circulatory System |
| | DRG 120 (Other O.R. procedures) |
| | 251 Destruction tongue les |
| | 863 Other local destruc skin |
| | 5591 Renal decapsulation |
| | MDC 06 - Diseases and Disorders of the Digestive System |
| | DRGs 146 and 147 (Rectal resection) |
| | 688 Pelvic evisceration |
| | DRGs 152 and 153 (Minor small and large bowel procs.) |
| | 5684 Close ureter fistula NEC |
| | 5783 Repair rectovesical fistula |
| | 6942 Closure uterine fistula |
| | 7075 Repair vag fistula NEC |
| | 7172 Repair vulvar fistula |
| | DRGs 154, 155, and 156 (Stomach, esophageal and duodenal procs.) |
| | 293 Ex. or destr. of lesion or tissue of pharynx |
| | 3173 Trachea fistula clos NEC |
| | 3805 Thoracic vessel resect/anast |
| | 3835 Thor vessel resec/anast |
| | 3845 Thor ves resect w replac |
| | 3865 Thoracic vessel excision |
| | 3885 Occlude thoracic ves NEC |
| | 5183 Pancreat sphincteroplas |
| | 527 Rad pancreaticoduodenect |
| | DRGs 170 and 171 (Other digestive procedures) |
| | 3804 Incision of aorta |
| | 3949 Vasc. proc revision NEC |
| | 3991 Freeing of vessel |
| | 5103 Cholescystostomy NEC |
| | MDC 07 - Diseases and Disorders of the Hepatobiliary System and Pancreas |
| | DRG 201 (Other Hepatobiliary or Pancreas O.R. Procedure) |
| | 4439 Gastroenterostomy |

TABLE 6 - CHANGES TO GROUPER PROGRAM

| PROBLEM | GROUPER MODIFICATION |
|---|---|
| | MDC 08 - Diseases and Disorders of the Musculoskeletal Sys. and Connective Tiss. |
| | DRG 217 (Wound debridement and skin graft exc. hand) |
| | 8665 Heterograft to skin |
| | 8666 Homograft to skin |
| | 8671 Cut. prep. ped graft |
| | 8672 Pedicle graft advancement |
| | DRGs 233 and 234 (Other musculoskel. sys. and connect. tiss. O.R. procs.) |
| | 1651 Radical orbitomaxillect |
| | 1659 Orbital exenteration NEC |
| | 2172 Open reduction nasal fx |
| | 2262 Exc max sinus lesion NEC |
| | 3327 Other lung biopsy |
| | 3481 Excise diaphragm lesion |
| | 4051 Rad dissec axillary node |
| | 4052 Rad dissec periaort node |
| | 4053 Rad dissect illac nodes |
| | 4054 Radical groin dissection |
| | 4059 Rad node dissection NEC |
| | 5900 Retroperit dissect NOS |
| | 6241 Remove both testes |
| | DRGs 226 and 227 (Soft tissue procedures) |
| | 543 Destruc abdom wall les |
| | 864 Radical excis skin les |
| | 8681 Repair facial weakness |
| | MDC 09 - Diseases and Disorders of the Skin, Subcutaneous Tissue & Breast |
| | DRG 268 (Skin, subcutaneous tissue and breast plastic procs.) |
| | 0838 Correct lid retraction |
| | 2755 Full-thick grft to mouth |
| | 2756 Skin graft to mouth NEC |
| | 2769 Oth plastic repair palat |
| | 8289 Hand plastic op NEC |
| | DRGs 269 and 270 (Other skin, subcutaneous tissue and breast O.R. procs.) |
| | 0609 Incis thyroid field NEC |
| | 0722 Unitateral adrenalectomy |
| | 073 Bilateral adrenalectomy |
| | 0763 Part excis pituitary NOS |
| | 0764 Tot exc pituit-transfron |
| | 0765 Tot exc pituit-transsphen |
| | 0768 Total exc pituitary NEC |
| | 0769 Total exc pituitary NOS |
| | 0772 Pituitary gland incision |
| | 0779 Pituitary operation NEC |
| | 0823 Exc major les lid, part-thick |
| | 6561 Remove both tubes and ovar |
| | 6711 Endocervical biopsy |
| | 6712 Cervical biopsy NEC |
| | 6719 Cervical dx procedur NEC |
| | 6739 Cervical les destruc NEC |
| | 7024 Vaginal biopsy |
| | 7111 Vulvar biopsy |
| | 7119 Vulvar diagnos proc NEC |
| | MDC 10 - Endocrine, Nutritional and Metabolic Diseases and Disorders |
| | DRGs 292 and 293 (Other endocrine, nutritional and metabolic O.R. procs.) |
| | 3426 Other mediastinal biopsy |

TABLE 6 - CHANGES TO GROUPER PROGRAM

| PROBLEM | GROUPER MODIFICATION |
|---|---|
| | 3802 Head/neck ves incis NEC |
| | 3829 Blood vessel dx proc NEC |
| | 3830 Vessel resect/anest NOS |
| | 3833 Arm vessel resect/anast |
| | 3838 Leg artery resect/anast |
| | 3843 Arm ves resect w replace |
| | 3848 Leg artery resec w repla |
| | 3855 Thorac var v lig-strip |
| | 3863 Arm vessel excision |
| | 3868 Leg artery excision |
| | 3883 Occlude arm vessel NEC |
| | 3888 Occlude arm vessel NEC |
| | 3925 Aorta-iliac-femor bypass |
| | 3931 Suture of artery |
| | 3941 Postop vasc op hem contr |
| | 3949 Vasc proc revision NEC |
| | 3956 Repair vess w tis patch |
| | 3957 Rep vess w snyth patch |
| | 3958 Repair vess w patch NOS |
| | 3959 Repair of vessel NEC |
| | 3991 Freeing of vessel |
| | 544 Destruct peritoneal tiss |
| | MDC 11 - Diseases and Disorders of the Kidney and Urinary Tract |
| | DRGs 310 and 311 (Transurethral Procedures) |
| | 6012 Other biopsy of prostate |
| | DRG 315 (Other kidney and urinary tract O.R. procs.) |
| | 0681 Total Parathyroidectomy |
| | 0689 Other parathyroidectomy |
| | 3806 Abdomen artery incision |
| | 3807 Abdominal vein incision |
| | 3816 Abdominal endarterectmy |
| | 3836 Abd vessel resect/anast |
| | 3837 Abd vein resect and anast |
| | 3846 Abd artery resc w repla |
| | 3847 Abd vein resect w replac |
| | 3866 Abdominal artery excis |
| | 3867 Abdominal vein excision |
| | 3886 Occlude abd artery NEC |
| | 3887 Occlude abd vein NEC |
| | 3952 Aneurysm repair NEC |
| | 3956 Repair vess w tis patch |
| | 3957 Repair vess w synth patch |
| | 3958 Repair vess w patch NOS |
| | 3959 Repair of vessel NEC |
| | 5493 Create cutaneoperiton fist |
| | 8622 Wound debridement |
| | MDC 12 - Diseases and Disorders of the Male Reproductive System |
| | DRGs 334 and 335 (Major male pelvic procs.) |
| | 4869 Rectal resection NEC |
| | 5411 Exploratory laparotomy |
| | DRGs 344 and 345 (Other male reproductive Sys. O.R. procs.) |
| | 5641 Partial ureterectomy |
| | 5751 Excision of urachus |

TABLE 6 - CHANGES TO GROUPER PROGRAM

| PROBLEM | GROUPER MODIFICATION |
|---|---|
| | MDC 13 - Diseases and Disorders of the Female Reproductive System |
| | DRG 360 (Vagina, cervix and vulva-procedures) |
| | 4873 Closure of other rect fistula |
| | 7023 Cul-de-sac biopsy |
| | 7029 Vagin/cul-de-sac dx NEC |
| | 7119 Vulvar diagnos proc NEC |
| | DRG 365 (Other female reproductive system O.R. procs.) |
| | 5641 Partial ureterectomy |
| | 5734 Bladder biopsy NEC |
| | 5751 Excision of urachus |
| | 5759 Open Ex or dest oth les ortis of blad |
| | 576 Partial cystectomy |
| | 5771 Radical cystectomy |
| | 5779 Total cystectomy |
| | 5902 Oth lys of periter adhes |
| | 5909 Perirenal/ureterexc NEC |
| | 5919 Oth incis of perives tiss |
| | 7012 Culdotomy |
| | MDC 14 - Pregnancy, Childbirth and the Puerperium |
| | DRG 374 (Vaginal delivery with sterilization and/or O.C.) |
| | 6697 Bury fimbriae in uterus |
| | DRG 375 (Vaginal delivery with O.R. proc. except steril. and/or D.C.) |
| | 387 Plication of vena cava |
| | 4024 Excise inguinal node |
| | 403 Regional lymph node exc |
| | 5411 Exploratory laparotomy |
| | 5421 Laparoscopy |
| | 680 Hysterotomy |
| | MDC 16 - Blood, Blood Forming Organs and Immunological Diseases and Disorders |
| | DRG 394 (Other O.R. procs. of the blood and blood forming organs) |
| | 400 Incis lymphatic structur |
| | MDC 17 - Myeloproliferative Diseases and Poorly Differentiated Neoplasms |
| | DRG 400 (Lymphoma or leukemia with major O.R. proc.) and |
| | DRGs 406 and 407 (Myeloprolif, disord. or poorly diff. neopl. with maj. O.R. With C.C.) |
| | 3229 Destroy loc lung les NEC |
| | 343 Destruct mediastin les |
| | 0371 Spin subarach-peritoneal shunt |
| | 0372 Spin subarach-ureteral shunt |
| | 0379 Other shunt spinal theca |
| | 410 Bone marrow transplant |

TABLE 6 - CHANGES TO GROUPER PROGRAM

| PROBLEM | GROUPER MODIFICATION |
|---|---|
| MDC 21 - Injury, Poisoning and Toxic Effects of Drugs | |
| DRGs 442 and 443 (Other O.R. procedures for injuries) | |
| 0141 | Thalamus operations |
| 0201 | Linear craniectomy |
| 0444 | Tarsal tunnel release |
| 0780 | Thymectomy NOS |
| 0781 | Part excision of thymus |
| 0782 | Total excision of thymus |
| 0791 | Thymus field exploration |
| 0792 | Incision of thymus |
| 0793 | Repair of thymus |
| 100 | Remov embed FB conjunct w incis |
| 110 | Magnet remov embed FB cornea |
| 111 | Corneal incision |
| 1372 | Secondary insert lens |
| 138 | Implanted lens removal |
| 139 | Other operations on lens |
| 1839 | Excis external ear NEC |
| 214 | Resection of nose |
| 2169 | Turbinectomy NEC |
| 245 | Alveoloplasty |
| 2792 | Mouth incision NOS |
| 2799 | Oral cavity ops NEC |
| 287 | Hemorr contri post T and A |
| 2891 | Incis to remov tonsil FB |
| 290 | Pharyngotomy |
| 294 | Plastic op on pharynx |
| 2953 | Closure pharynx fistula NEC |
| 2959 | Pharyngeal repair NEC |
| 2999 | Pharyngeal operation NEC |
| 301 | Hemilaryngectomy |
| 3021 | Epiglottidectomy |
| 3022 | Vocal cordectomy |
| 3029 | Other part laryngectomy |
| 303 | Complete laryngectomy |
| 3173 | Trachea fistula clos NEC |
| 3199 | Other tracheal operation |
| 321 | Other bronchial excision |
| 330 | Incision of bronchus |
| 331 | Incision of lung |
| 3392 | Bronchial ligation |
| 3398 | Bronchial operation NEC |
| 3399 | Lung operation NEC |
| 341 | Incision of mediastinum |
| 3421 | Transpleura thoracoscopy |
| 3489 | Diaphragm operation NEC |

TABLE 6 - CHANGES TO GROUPER PROGRAM

| PROBLEM | GROUPER MODIFICATION | |
|---|---|---|
| | 3499 | Thoracic operation NEC |
| | 3711 | Cardiotomy |
| | 537 | Abd repair-diaphr hernia |
| | 5380 | Thor rep-diaph hern NOS |
| | 5381 | Diaphragmatic plication |
| | 5382 | Parastern hernia repair |
| | 5553 | Rejected kidney nephrect |
| | 5554 | Bilateral nephrectomy |
| | 576 | Partial cystectomy |
| | 5779 | Total cystectomy NEC |
| F. DOCUMENTATION ISSUES | | |
| 1. Some of the language in the DRG documentation is not completely descriptive of the classification of cases. | Make the following changes to the DRG documentation: | |

- Update MDC tree diagrams to reflect the surgical hierarchy of each MDC. The tree diagrams have each surgical group ordered from top to bottom in hierarchical order. Since DRG numbers are not changed, the trees no longer increase in numerical order from left to right.
- In the medical partitioning section of MDC 5 (Diseases and Disorders of the Circulatory System), change the labels to better define the list of "Cardiovascular Complications" and "Complex Cardiovascular Diagnoses."
- Remove procedure codes 431 (Temporary Gastrostomy) and 7022 (Culdoscopy) from the list of operating room procedures in MDC 3 and MDC 14, respectively. These codes do not appear in the list of operating room procedures and are not considered by GROUPER to be operating procedures.
- The title of the branching criteria in the tree diagram for DRG 115 (Permanent Cardiac Pacemaker Inplant with AMI or CHF) is changed from "Principal Diagnoses of AMI or CHF" to "Principal Diagnoses of AMI, Heart Failure or Shock."
- The title of the branching criteria in the tree diagram for DRGs 164 and 165 (Appendectomy With a Complicated Principal Diagnoses) is changed from "Complicated Diagnosis" to "Complicated Principal Diagnosis."
- The title of the branching criteria in the tree diagram for DRG 303 (Kidney, Ureter and Major Bladder Proc. for Neoplasm) is changed from "Principal Diagnosis of Malignancy" to "Principal Diagnois of Neoplasm.

These changes are editorial in nature and do not affect in any way the classification of cases.

TABLE 6 - CHANGES TO GROUPER PROGRAM

| PROBLEM | GROUPER MODIFICATION |
|---|---|
| **2. Some of the operating room and nonoperating room codes are erroneously listed. | Make the following changes:<br>* Remove operating room procedures 3421, 3422, and 5421 from the nonoperating room procedure listing for DRG 412 (History of Malignancy With Endoscopy)<br>* Remove nonoperating room code 431 from the list of operating room procedures for DRG 63 (Other Ear, Nose and Throat O.R. Procedures).<br>* Remove nonoperating room code 7022 from the list of operating room procedures for DRG 375 (Vaginal Delivery With O.R. Procedure Except Sterilization and/or D and C). |

* These items have been revised based on public comments.
** These items have been added to the table based on public comments.

BILLING CODE 4120-01-C

## Appendix—Regulatory Impact Analysis

*A. Introduction*

Executive Order 12291 requires us to prepare and publish a regulatory impact analysis for any major rule. A major rule is defined as any regulation that is likely to result in: (1) An annual effect on the economy of $100 million or more, (2) a major increase in costs or prices for consumers, individual industries, government agencies, or geographic regions, or (3) significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets. Consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), we also prepare and publish a regulatory flexibility analysis for regulations unless the Secretary certifies that the regulations would not have a significant economic impact on a substantial number of small entities.

Several provisions of this final rule will exceed the $100 million threshold under E.O. 12291. Therefore, we are including an impact analysis that contains a discussion of each significant change. In our summary, we discuss the expected net effects resulting from these changes.

Under the RFA, we treat all hospitals as small entities. It is clear that the changes contained in this final rule will affect all hospitals, and the effects on some may be significant. Therefore, we are providing a regulatory flexibility analysis.

The discussion below, in combination with the preamble of this final regulation, constitutes a combined regulatory impact analysis and regulatory flexibility analysis meeting the requirements of E.O. 12291 and the RFA.

*B. Objectives*

We expect the changes contained in this rule to further our original objectives in implementing the prospective payment system, which include:

- Creating incentives for efficiency, which translates into lower rates of increase in hospitals' costs and reduction of expenditures from the Medicare trust fund;
- Basing payment on a system that identifies the product being purchased more accurately than cost reimbursement; and
- Reinforcing the role of the Federal Government as a prudent buyer of services.

We believe these regulations will further our goals while maintaining the financial viability of the hospital industry and assuring access to high quality care for beneficiaries.

We expect these changes to further our objectives while avoiding or minimizing unintended adverse consequences and ensuring that outcomes of this payment system, in general, are reasonable and equitable. Thus, the intent is to refine further the prospective payment system without undercutting our objectives.

*C. Problems of Impact Quantification and Attributing Causality*

In previously published interim and final rules, we discussed the objectives and impacts of the rules largely in general conceptual terms. We did not always have adequate data, analytic resources, or time to perform a detailed quantitative impact analysis of particular provisions for publication with these previous rules. However, we did solicit comments and information that would enable us to describe and quantify better the anticipated effects of the Medicare prospective payment system.

As noted in the NPRM, we still have no adequate way to model potential behavioral changes on the part of hospitals, hospital managers and employees, physicians, suppliers, or beneficiaries. Much of the available Medicare program data reflect only patterns and trends of utilization and payment. Also, much of our data still reflects hospital behavior under cost reimbursement. Where it is feasible and appropriate, we have used these data to model and analyze the effects of particular proposals. Nonetheless, any of the quantitative estimates given below should be viewed with a qualified recognition of the limitations of the data on which they are based.

A second problem that limits our ability to quantify the effects of this rule is attributing the causation of particular changes in the hospital industry directly to specific statutory or regulatory provisions. This is made especially difficult by the changing nature of the health care sector. The prospective payment system is but one of numerous efforts aimed at controlling rapidly rising health care costs. In many cases, then, it may be difficult to determine the extent that the prospective payment system, or some other initiative, caused the result, or whether two (or more) initiatives caused the result interactively.

Apart from the more easily identifiable initiatives that are affecting the health care market, especially on the demand side, changes also have been occurring on the supply side. Most notable of the latter, is the increase in the supply of physicians, which enhances the competition for patients among providers. There has also been a significant growth of facilities furnishing out-of-hospital treatment. For example, since 1973, 2,000 ambulatory care clinics have opened. There are currently about 300 ambulatory surgical centers participating in Medicare, with another 100 awaiting approval. In addition, home health services are the fastest growing component of the Medicare program.

The multiple changes in the health care system require the use of caution in attributing positive or adverse effects to one or another initiative or policy change. However, the incentives provided by prospective payment are identifiable, and the system has been implemented and is revised on a regular schedule. Therefore, it is possible to attribute some of the effects resulting from this payment system to the system itself and to changes to its structure.

*Comment:* Several commenters expressed dissatisfaction with the degree and extent of analysis published in the NPRM. For example, one commenter felt that the summary table showing relative (percent) impacts (50 FR 24438) was not specific enough; the commenter believes that we should have examined and presented the impact of recalibration on specific hospitals. Several commenters argued that the effects of reclassifying DRGs should have been separately identified and presented.

*Response:* We disagree with commenters who claim that we should publish an analysis of the impact of recalibration or any other changes on specific hospitals. E.O. 12291 and the RFA require us to identify affected entities in general. An analysis of potential effects on specific entities would go substantially beyond those requirements. Further, we believe that the lower the level of aggregation of the data available to us, and the more specific the focus of analysis of that data, the less reliable are the results.

We have tried to present an analysis of impacts that would be consistent with the national scope of the program. We recognize that payment amounts hinge on urban/rural status and census division, and that impacts vary significantly by hospital size. We have, therefore, prepared a simple and understandable summary table of the relative impacts for hospitals using those identifying criteria. We believe that this meets both the letter and the intent of the requirements of E.O. 12291 and the RFA.

More importantly, we are aware of the limitations of our data. Seeking to use it to assess impacts on very small groups or individual hospitals would be misleading and methodologically unjustifiable. As the level of data aggregation is lowered, the magnitude of distortions caused by anomalies and undetected errors in the data base increase. Hospital-specific analyses would have a very high risk of encouraging misleading or inaccurate conclusions, and providing such analyses would be irresponsible. Moreover, hospital-specific analyses necessarily rely on historical cost data, and since we do not yet have complete hospital cost data under prospective payment, we cannot quantify the effects of changes in hospital behavior on costs. Consequently, affected hospitals are in a better position than we are to estimate the probable impact of the changes on their specific operations.

We agree that we are obligated to analyze the impact of changes to the prospective payment system to the extent that time, resources, and the availability, accuracy, and completeness of data permit. In fact, the very table that elicited these comments was the product of our efforts to provide more such analysis than we had been able to provide during the first two years of the prospective payment system. We believe it afforded hospitals a reasonable framework for grouping the probable effects of the proposals. Nevertheless, we agree with some commenters that there are some aggregate analyses that we could have provided that would have been helpful to them. Therefore, we are providing further analysis and expanded tables below.

In view of the problems we have experienced in quantifying impacts and attributing causality, we believe that the approach we are taking in the specific impact discussions below is the best feasible. In some cases we have included quantitative estimates of program savings. However, since it is not possible to develop a reliable quantitative analysis and comparison of the costs and benefits of all the provisions to the various affected parties, we have primarily focused on explaining the kinds of interactions, and the decisions, which those parties will have to consider.

*D. Hospitals Included in and Excluded From the Prospective Payment System*

Since October 1983, hospitals operating under prospective payment have been phasing-in to the system according to their own accounting year starting dates. As of September 1984, 5,405 hospitals (81 percent of all hospitals) were operating under the prospective payment system. This represents virtually 100 percent of all hospitals currently subject to the new payment system. As of May 1985, 1,249 Medicare-participating hospitals were excluded from the prospective payment system and continue to be paid either on the basis of reasonable cost reimbursement (for example, psychiatric, long-term care, and children's hospitals) or on the basis of special reimbursement methodologies in waiver States. Another 1,489 psychiatric, rehabilitation, and alcohol/drug units of hospitals were excluded from prospective payment as of the same date.

Additionally, as of May 1985, 454 hospitals were being paid on a special basis under the prospective payment system. They included hospitals accorded special treatment under our regulations at 42 CFR Part 412, Subpart G, such as sole community hospitals and cancer treatment and research hospitals. Also included in this group receiving payment on a special basis are referral centers and hospitals that previously allowed extensive direct billing under Part B.

*Comment:* We received a significant number of comments requesting that we extend the exclusion from prospective payment by one year for alcohol and drug treatment centers and units.

*Response:* As of June 4, 1985, 23 hospitals and 317 units that furnish alcohol and drug treatment services have been excluded from the prospective payment system under §§ 412.23 and 412.32 of our regulations. Exclusion was afforded these hospitals and units on a temporary basis because of difficulties associated with implementation of DRGs for the related services. As discussed in the preamble of this final rule, we have decided to extend the exclusion for one additional year to those hospitals and units that were excluded from the system for their cost reporting periods beginning during Federal FY 1985.

Because the exclusion is mandatory for hospitals and units that meet the requirements in § 412.23 or § 412.32, we do not believe that our decision to extend it for a year will cause a significant change in the number of excluded units. There is a possibility that a few institutions or units would be adversely affected if required to join the prospective payment system at present and we are concerned that beneficiaries' treatment not be adversely affected.

*E. DRG Classification and Weights*

1. Recalibration

We are making certain changes in the DRG classification system and recalibrating the DRG weights based on 1984 PATBILL charge data. The changes we are making are discussed in detail in section II of the preamble.

The advantages of using newer and more complete data from the PATBILL file outweigh both the potential disadvantages of using charges, and the advantages of using currently available cost report data. Charges appear to be a valid measure of relative resource use, at least on the basis of historical data, the existing DRG classifications, and the current methodology for deriving DRG weights. Use of 1984 charge information would also explicitly incorporate the effects of changes in hospital behavior, whereas the 1981 cost data would not.

Since its implementation in October 1983, the prospective payment system has used DRG relative weights calculated by a complex methodology using data from the 1981 MEDPAR file, a 1981 Medicare Cost Report abstract file, and a 1981 hospital wage index based on hospital wage information collected by BLS. These cost-based relative weights were used in the Medicare prospective payment system on the assumption that they would better reflect differences in true resource costs among DRGs than would relative weights derived from charges. However, as discussed in section II of the preamble, charge data have some potential advantages compared to operating cost data. Weights based on charges could be constructed without cost report data, which is typically two to three years old before it becomes available for analysis. Charge-based relative weights are also simpler to compute, since complex adjustments are not required to convert charges to costs and to remove capital and medical education costs. Because of these potential advantages of charge-based weights, we initiated a study to determine whether it would be feasible to recalibrate the DRG relative weights on the basis of charges rather than costs.[1]

Using the 1981 data upon which the prospective payment system was based, this study investigated the extent to which relative weights based on costs differ from relative weights derived

[1] Philip Cotterill, Joel Bobula, and Rose Connerton, "A Comparison of Alternative DRG Relative Weights for the Medicare Prospective Payment System." HCFA Internal Working Paper, February 1985.

exclusively from charge data. The study also assessed the validity of a case-mix index developed from charge-based relative weights as a measure of the relative costliness of a hospital's Medicare cases. The main findings of the analysis indicate that charge-based and operating cost relative weights, based on 1981 MEDPAR data, are very similar, as follows:

- The difference between relative weights based on operating costs and relative weights based on total charges is less than five percent for most of the DRGs.
- The structure of the relative weights across DRGs for each method are also very similar. The Spearman and Pearson correlation coefficients are greater than .99.
- The relative dispersion of costs or charges within a DRG are also very similar, although for most DRGs the coefficients of variation are slightly higher using charge data than the coefficients of variation using cost data.
- The dispersion of average costs or charges across DRGs are also very similar. However, DRGs with high (low) relative weights tend to have slightly higher (lower) relative weights if computed using charge data rather than cost data.
- Large, urban hospitals and teaching hospitals tend to have slightly higher case-mix index values using charge-based weights rather than cost-based weights, whereas small, rural hospitals and nonteaching hospitals tend to have slightly lower case-mix index values using charge-based weights.

The results of the analysis support the use of charge data in constructing DRG relative weights. We believe that differences among hospitals in cost-to-charge ratios do not result in large, arbitrary differences between charge-based and operating cost weights.

Whether the data are standardized for differences in capital and medical education costs also appears to make little difference. These inter-hospital differences would only affect the DRG relative weights if there were a high degree of specialization among hospitals in different groups of DRGs they treat. Our results indicate that, in 1981, hospitals' case mixes were similar enough that most inter-hospital effects disappear when the data are partitioned by DRG.

In addition, we analyzed the relationship between hospitals' 1981 Medicare cost per case and their case-mix index values constructed from the charge-based relative weights. Using multiple regression analysis, the charge-based case-mix index was found to be approximately proportional to the expected costliness of an individual hospital's Medicare patient mix. This result further supports the study's major finding that there do not appear to be large differences between charge-based and cost-based weights, or between case-mix indexes constructed from charge-based or cost-based weights.

2. Proposed New Weight Values

Table 5 in section IV of the Addendum to this rule sets forth the recalibrated DRG weights. This table reflects all the reclassifications and GROUPER changes discussed in section II of the preamble. The revised DRG weights are highly correlated with the published FY 1985 DRG weights. The Pearson correlation coefficient for the two sets of relative weights is .95.

The changes in values for particular DRGs are affected by a number of factors other than the use of charge data. In fact, we believe that the use of charge data accounts for a smaller proportion of the change in weights than some of the other factors. The changes are accounted for largely by GROUPER changes and behavioral changes that are reflected in the more recent data base.

Approximately 83 percent of FY 1984 discharges fell into DRGs for which the revised weights will differ from the FY 1985 weights by less than 15 percent. Nonetheless, 125 DRGs have weights that will differ from their previous weights by 15 percent or more. Of these, 60 will increase and 65 decrease. Only about 6 percent of all FY 1984 discharges occurred in DRGs with weights that will decrease more than 15 percent, whereas about 11 percent occurred in DRGs with more than a 15 percent increase.

Many of the DRGs that show weight changes of more than 15 percent have relatively low Medicare case frequencies. Thirty-five of the DRGs that will go up more than 15 percent are DRGs for which non-Medicare data was used to calculate their previous weights. These 35 DRGs account for only about 2.3 percent of the cases that fall into the 60 DRGs that will increase by more than 15 percent. More than half of the cases in the 60 high-increase DRGs are in only 3 DRGs: DRG 39 (lens procedures) will increase 15.4 percent, DRG 148 (major bowel procedures) will increase 16.6 percent, and DRG 468 (unrelated OR procedure) will increase 17.9 percent. Further, among the 25 most common DRGs, only DRGs 39, 148, and 468 will increase by 10 percent or more.

Each hospital will have to assess the effect of the revised DRG weights for itself. As noted elsewher, the general tendency of the recalibration is to decompress both charge weights and case-mix index values, so that the higher weights and index values are, on average, a little higher, and the lower ones are, on average, a little lower. However, the degree to which this occurs will vary from hospital to hospital. Further, changes in the DRG weights will interact with changes in Federal rates, wage indexes, and the blending of Federal and hospital-specific portions. (See additional discussion in section J below.)

3. Alcohol and Drug-Related DRG Reclassification

As previously discussed, we have decided to allow an extension of one year, of limited application, to the time-limited exclusion from prospective payment for alcohol and drug treatment centers and units. We have, however, reclassified the alcohol and drug-related DRGs to better reflect the patterns of practice in alcohol and drug detoxification and rehabilitation services. Thus, for cost reporting periods beginning in FY 1986, the revised weights will be applied to alcohol and drug-related services furnished by hospitals under the prospective payment system.

We are replacing the six DRGs in the previous classification for this MDC with five DRGs. The revised weights for DRGs 436 and 437 (rehabilitation therapy and combined detoxification and rehabilitation treatment) are higher than the weights for treatment without rehabilitation. However, there are many more cases in the DRGs for treatment without rehabilitation (DRGs 433 to 435). As a result, the average weight for the cases in the alcohol and drug-related MDC, taken as a whole, will decline about 5 percent.

*F. Wage Index*

1. Background

As discussed in section III of the preamble, this final rule incorporates a new wage index based on our own survey data rather than on the hospital wage and employment data obtained from the ES 202 reporting system of BLS. The new survey-based wage index will be applied in two ways:

- Prospectively, to restandardize hospitals' operating costs per case to remove the effects of wage differences (as measured by the HCFA gross wage index) in computing the Federal rates; and
- Retroactively, to determine overpayments and underpayments resulting from the use of a wage index based on BLS data since the implementation of the prospective

payment system for cost reporting periods beginning on or after October 1, 1983.

The revised wage index is discussed in detail in the *Report on Hospital Wage Index Required by Section 2316(a) of Public Law 98–369*, submitted to Congress by the Department on March 29, 1985. That report includes detailed estimates of the effects of implementing the proposed index and an alternative wage index that we considered using, based on certain adjustments to the survey data to exclude wages and salaries for certain classes of hospital employees.

2. Prospective Impact of the New Index

Implementation of the survey-based gross wage index prospectively for cost reporting periods beginning on or after October 1, 1985 will have several effects. Of course, each hospital will be relatively advantaged or disadvantaged according to whether the wage-adjusted Federal rates for its geographic area increased or decreased. (Note, however, that a number of other factors will affect whether a hospital's actual total prospective payment revenue increased or decreased.) In addition, the new index will be used to restandardize the standardized amounts on which the Federal national and regional rates are based. This should have a negligible effect on the national urban and rural rates, but will affect the relative level of regional rates significantly.

Since FY 1986 is the last year during which regional rates will be included in the blended Federal rates, this secondary impact of the new index will be time-limited. Nonetheless, for FY 1986, some regional rates will go up and others will go down, with concomitant advantages and disadvantages for affected hospitals.

All hospitals under the prospective payment system will be affected, although some only slightly. For FY 1986, affected hospitals will fall into four groups, as follows:

- Those doubly advantaged by increases to both their wage index values and their regional rates;
- Those doubly disadvantaged by decreases to both their wage index values and their regional rates;
- Those advantaged by an increased wage index value and relatively disadvantaged by a revised regional rate; and
- Those disadvantaged by a decreased wage index value and relatively advantaged by a revised regional rate.

In addition, the changes to the wage index will interact with changes to the DRG weights, the effects of the increased proportion of the national rate in the Federal rate, and the change in blending proportions between Federal and hospital-specific portions. (For further discussion, see section J. below, especially the table summarizing the anticipated percent payment changes for FY 1986.)

4. Retroactive Impact of the New Index

Under section 2316(b) of Pub. L. 98–369, any new wage index that is adopted as a result of the study conducted in accordance with section 2316(a) must be implemented retroactively for hospital cost reporting periods beginning on or after October 1, 1983.

As explained previously, we will begin making refunds to underpaid hospitals and collecting from overpaid hospitals after April 1, 1986, absent any Congressional action on this issue. Because the revised wage index is implemented effective October 1, 1985, some hospitals (that is, those whose reporting periods began October 1, 1983) will have been paid using the BLS index for two full years. If a hospital's payments based on a revised wage index are higher than its payments using the previous index, the Medicare program will have to compensate the hospital for the underpayments. Conversely, where a hospital has been overpaid using the previous index compared to what it will be paid using the revised index, the program will have to recoup the overpayments that have been made.

*G. Excluded Hospitals*

As discussed in section III. of the Addendum, for cost reporting periods beginning in FY 1986, each hospital or unit subject to the rate-of-increase limits (§ 405.463) will have a target amount equal to the target amount for its previous cost reporting period. We estimate that this will result in $20 million in savings for FY 1986 Medicare Part A expenditures, compared to the maximum level of expenditures allowable under law.

The effect this will have on affected hospitals and units will vary depending on each one's existing relationship of costs per discharge to its target amount for FY 1985, any increase in inpatient costs from FY 1985 to FY 1986, and the relative gains in productivity (efficiency) the hospital or unit is able to achieve. For hospitals and units that continue to achieve per discharge costs lower than their target amounts, the primary impact will be a reduction of the level of additional payments made under § 405.463(d)(2) proportional to the increases in per-discharge costs.

For hospitals and units whose costs are currently in excess of their target amounts, we would expect FY 1986 excess costs to increase, unless the hospitals are able to achieve significant productivity improvements.

In general, we expect the continued ceiling on payments to increase existing incentives for economy and efficiency experienced by excluded hospitals and units. We do not believe that even these limits would achieve incentives comparable to those produced by the prospective payment system. Therefore, we will, as required under the law, continue to study means for establishing an appropriate prospective payment methodology for those hospitals and units that are currently excluded from the prospective payment system. Nonetheless, we believe this decision will ensure that services furnished to beneficiaries by affected hospitals and units will, for the most part, be paid for at a level no higher than necessary for the efficient delivery of needed health services.

*H. Indirect Medical Education Costs*

As noted in the NPRM, we are changing the way interns and residents are counted for purposes of making payment for the indirect costs of medical education. The indirect medical education payment would be computed based on the ratio of interns and residents to beds, including only those interns and residents furnishing services paid for under the prospective payment system. We are also changing the requirements for counting interns and residents from using actual hours worked at the hospital and reported quarterly, to a one-time count on September 1 of each year or, should September 1 fall on a weekend or holiday, the first workday thereafter.

We anticipate that the change in our counting of interns and residents will result in levels of payment that are reflective of the actual intensity of teaching activity during the cost reporting period. In addition, we estimate budget savings to result from eliminating duplicate payments for the indirect costs of intern and resident time spent furnishing services to hospital outpatients.

We estimate payments of $1.510 billion in FY 1986 and $2.294 billion in FY 1987 to about 975 participating hospitals for their related indirect medical education expenses. As discussed below, we anticipate reductions in payments to most of these hospitals due to implementation of the provisions of this final rule dealing with the method of counting interns and

residents. However, we cannot quantify these reductions in payment because of the absence of adequate data regarding interns' and residents' time spent furnishing services to outpatients. Several commenters submitted their own data concerning residents' time furnishing services to outpatients. The comments suggest that residents' time spent treating outpatients varies widely among programs and depends on the residents' specialties.

However, the estimates submitted by different comments are neither comparable, nor sufficient, to form the basis of a reliable budget estimate. Therefore, although we cannot estimate potential savings, based on what information is available, we have some indication that savings will be far greater than we stated in the NPRM's analysis.

The primary effect on those hospitals whose intern and resident programs include time spent furnishing services to outpatients will be a reduction in indirect medical education payments. The actual impact on a particular hospital would be related to the volume of services its interns and residents furnish to outpatients for which additional indirect medical education payments will not longer be made. The distribution of the impact will vary according to characteristics of hospitals, including: regional and urban/rural settings; bed size; the amount of reimbursement that is related to time spent furnishing services to outpatients and actions hospitals are taking to control the operating costs associated with their training programs. Limiting our payment to affected hospitals may lead to changes in the distribution of residents' time. However, we are unable to predict what specific actions these hospitals will take in response to this change in our payment policy.

In addition to the impact of this particular regulation, some hospitals and their medical education programs have been affected by the limits on payments for direct medical education costs published on July 5, 1985 (50 FR 27722). On page 27730 of that final rule, we discussed the anticipated impact of that limitation on certain hospitals incurring direct medical expenses. For those hospitals that are affected by both the direct medical education limitation and the provision of this final rule affecting indirect medical education payments, the impact of these provisions could well be additive and intermingle with the effects of the direct medical education regulation. However, we cannot determine the exact impact, either in the aggregate or on a particular hospital, due to the variation in hospital characteristics as discussed above and because of the absence of data regarding intern and resident treatment of outpatients.

*I. Referral Centers*

As discussed in section IV. E. of the preamble to this rule, we are updating the case-mix criteria for hospitals to qualify as referral centers under our regulations at § 412.96(c). Currently, there are about 150 referral centers, all but one of them rural hospitals, that are paid under the prospective payment system, on the basis of urban standardized amounts as a result of their referral center status.

More than 95 percent of the referral centers are eligible for higher payment because they meet the criteria of § 412.96(c) rather than those of § 412.96(b). These criteria refer to case-mix index, number of discharges, medical staff, source of inpatients, and volume of referrals. Each new qualifying hospital and those wishing to retain their referral center status must meet both the case-mix and discharge criteria, and at least one of the other criteria. Thus, the level at which the case-mix and discharge criteria are set determines whether a specific hospital meets the criteria.

We expect that a substantial number of the current referral centers will not meet the case-mix criterion that applies to cost reporting periods beginning in FY 1985. However, this will not result in their being terminated as referral centers, since once qualified, referral center status continues for three years. For the triennial review, they need meet the criteria only two out of three years. At this time, we are unable to determine how many hospitals may gain referral center status under the revised FY 1986 criteria. However, we believe the new criteria will afford us a reasonable measure of the degree to which hospitals seeking special treatment under this provision differ from the average rural hospital and resemble typical urban hospitals, nationally or in their region.

*J. Updated Payment Rates and Resulting FY 1986 Payment Amounts*

One of the primary functions of this final rule is to publish updated prospective payment rates in accordance with requirements in the law and regulations (section 1886(d) of the Act and § 412.8 of the regulations). Accordingly, the addendum to this document, which is printed after the text of the changes in the regulations, sets forth tables of new Federal national and regional rates, new DRG relative weights and outlier thresholds, and new factors for calculating hospital-specific rates. In accordance with section 1886(d)(1)(D) of the Act, the Federal rate for FY 1986 will be a blend set at 50 percent of the Federal regional rate plus 50 percent of the Federal national rate. This blend will take effect for all Federal rates for all discharges occurring on or after October 1, 1985. Further, as each hospital begins its third year under prospective payment, with its cost reporting period beginning on or after October 1, 1985, the relative proportions of hospital-specific and Federal portions will change from 50 percent and 50 percent, respectively, to 25 percent hospital-specific and 75 percent Federal.

In FY 1986, for the first time, the updated Federal rates (that is, the adjusted average standardized amounts) will not be adjusted to achieve "budget neutrality". Under section 1886(e)(1) of the Act, for FYs 1984 and 1985, the rates were adjusted so that estimated aggregate payments for inpatient hospital services would be the same as they would have been had the Medicare payment system in effect at the time of the prospective payment legislation continued in effect. This requirement for budget neutrality does not apply to rates for FY 1986 and thereafter.

In determining the level of the payments and the adjustment factors to be applied to them, such as DRG weights and wage index values, two issues of impact are paramount: the size of the prospective payment pie, which may be expressed in terms of either the average payment per case or the estimated total expenditures, and how that pie will be divided, that is, how payments will be distributed among DRGs or hospitals. Under budget neutrality, the size of the pie, expressed as average payment per case, was, to the extent it could be predicted and controlled, prescribed by law. As a result, in assessing the impacts of the revised rates, adjustments, and special treatment provisions of previous proposed rules, we focused primarily on the distributive effects of our proposals. This year, however, our primary concern is the proper level of payments, and the major alternatives we considered in setting the payment rates were assessed in light of this concern.

By the end of 1984, we realized that, despite our best efforts to achieve budget neutrality, the FY 1985 prospective payment rates were too high. As a result, in preparing the President's budget, we assumed that the FY 1986 payment rates would be

maintained at the FY 1985 level.[3] At that time, we did not realize that later data and experience would show that we would have substantial legal and technical justification to actually reduce the rates.

In the end, we had to choose among a fairly wide range of potential percentage changes. The hypothetical upper end was constrained by the legal requirement, under section 1886(b)(3)(B) of the Act, that rates for FY 1986 be increased by no more than the forecasted market basket increase plus one-quarter of one percentage point. Thus, the highest conceivable increase for the FY 1986 prospective payment rates was +4.52 percent.

On the other hand, as explained in section II.A.3. of the addendum of this rule, we had a number of reasons for finding the FY 1985 prospective payment rates too high. Considering the combined effect of case-mix increases, market basket forecasting error, inaccurate cost per case assumptions, and the consequences of using unaudited cost data as a basis for rate-setting, the FY 1985 rates are probably overstated by at least 9.8 percent.

ProPAC's first recommendation was a major alternative that had to be considered. It recommended increasing the FY 1985 rates by the forecasted market basket increase, minus one percentage point, plus an allowance for the estimated increase in real case-mix complexity during FY 1985. It described the negative one percentage point, or "discretionary adjustment factor," as a combined adjustment of a positive allowance for scientific and technological advancement and a negative allowance for productivity improvement and hospital product change. It also recommended that we made corrections for market basket forecasting error. In essence, by identifying a number of factors to be considered in determining an update percentage, including both negative and positive values, ProPAC performed an analysis very similar to ours.

In considering the same kinds of things as ProPAC did in developing its proposed discretionary adjustment factor, we developed categories and allowances with some analytic differences, but nonetheless arrived at a policy target adjustment factor of −1.5 percentage points, in lieu of their −1.0 percentage point factor.

In theory, it would be possible to choose to combine the various corrections, adjustments, and inflation factors in a variety of combinations, yielding nearly any percentage change between +4.52 percent and −9.8 percent. However, we believe the preponderance of the evidence, including recent industry reports on hospital profitability margins, shows that current payments are already set at levels that are at least adequate. Accordingly, in section II.A.3. of the addendum, we set forth the factors we believe are best, and show that these factors, in combination, would result in a −4.02 percent reduction of the FY 1986 prospective payment rates. For the reasons given in the Addendum, we are maintaining FY 1986 Federal rates at the same level as FY 1985.

The Federal rates change only as a result of restandardization of the base data to reflect the survey-based gross wage index. Further, as explained in section II. D. of the addendum, we are not increasing the hospital-specific rates for cost reporting periods beginning in FY 1986. As a result, the amounts a hospital may expect to receive from prospective payments for FY 1986 discharges will change as a result of the effects of the new wage index, the new DRG classifications and weights, and the statutorily required changes in blending of Federal and hospital-specific portions.

We have projected the separate and combined expected effects of changes to the DRG weights and wage index on payments to hospitals grouped by census regions, urban/rural status, bed-size, teaching status, and type of control (ownership). This estimate of payment changes is based on 5302 hospitals with Medicare discharges in the PATBILL file and for which hospital-specific information (hospital-specific rates, resident/bed ratios, rural referral center status, and so forth) was provided by the fiscal intermediaries. We did not include any hospitals from waiver States (Maryland, Massachusetts, New Jersey, New York) or hospitals excluded from the prospective payment system. This projection also reflects the impact of the statutorily required retroactive application of the survey-based wage index. The following table summarizes our findings.

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[3] *U.S. Budget in Brief, Fiscal Year 1986.* Executive Office of the President, Office of Management and Budget, Washington, D.C. February 4, 1985. Page 46.

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TABLE-ESTIMATED IMPACT OF CHARGE-BASED DRG WEIGHTS AND THE SURVEY-BASED WAGE INDEX ON FY 1986 OPERATING PAYMENTS

Percent Change in Total Payments for FY 1986 Due to:

| | DRG Recalibration[1] | Revised Wage Index [2] | Combined Prospective Effects[3] | Retroactive Wage Index Application | Total Combined Effects |
|---|---|---|---|---|---|
| All Hospitals | -0.01 | -0.08 | -0.09 | -0.11 | -0.20 |
| By Census Regions | | | | | |
| New England | 0.49 | 0.40 | 0.89 | 0.51 | 1.40 |
| Mid Atlantic | 0.47 | -0.51 | -0.04 | -0.59 | -0.62 |
| South Atlantic | -0.13 | -0.55 | -0.69 | -0.66 | -1.35 |
| East North Central | -0.13 | -0.11 | -0.24 | -0.17 | -0.41 |
| East South Central | -0.41 | -0.31 | -0.72 | -0.19 | -0.91 |
| West North Central | 0.03 | 0.19 | 0.22 | 0.14 | 0.37 |
| West South Central | -0.32 | -0.26 | -0.58 | -0.26 | -0.84 |
| Mountain | -0.13 | -0.06 | -0.19 | -0.10 | -0.28 |
| Pacific | 0.35 | 0.61 | 0.96 | 0.68 | 1.64 |
| Urban Hospitals | 0.13 | -0.07 | 0.06 | -0.10 | -0.04 |
| 0-99 Beds | -0.19 | 0.19 | -0.00 | 0.25 | 0.25 |
| 100-404 Beds | 0.06 | 0.04 | 0.10 | 0.04 | 0.14 |
| 405-684 Beds | 0.15 | -0.19 | -0.03 | -0.24 | -0.27 |
| 685 + Beds | 0.46 | -0.35 | 0.10 | -0.46 | -0.36 |
| Rural Hospitals | -0.65 | -0.13 | -0.78 | -0.15 | -0.93 |
| 0-99 Beds | -1.16 | -0.00 | -1.16 | -0.00 | -1.17 |
| 100-169 Beds | -0.43 | -0.05 | -0.48 | -0.05 | -0.53 |
| 170 + Beds | -0.12 | -0.38 | -0.50 | -0.44 | -0.94 |
| By Teaching Status[4] | | | | | |
| Non-teaching | -0.23 | -0.12 | -0.35 | -0.15 | -0.51 |
| Light-teaching | 0.06 | -0.04 | 0.02 | -0.04 | -0.01 |
| Heavy-teaching | 1.04 | -0.05 | 1.00 | -0.08 | 0.92 |
| By Type of Control | | | | | |
| Voluntary | 0.08 | -0.02 | 0.06 | -0.04 | 0.02 |
| Proprietary | -0.24 | -0.24 | -0.48 | -0.29 | -0.77 |
| Government | -0.29 | -0.25 | -0.53 | -0.31 | -0.84 |

1/ This is the combined effect of using charge weights and a revised GROUPER program.

2/ Prospective application only. This comparison reflects the difference we expect from using the HCFA gross index in FY 1986 as compared to estimated FY 1986 payments using the BLS index. It does not include MSA redesignations or other changes that would have occurred in any event.

3/ This is the combined effect of DRG recalibration and the revised wage index.

4/ Non-teaching hospitals are defined as those with 0 residents. Light-teaching hospitals are those with a ratio of residents-to-beds less than 0.25. Heavy-teaching hospitals are those with a ratio of residents-to-beds greater than 0.25.

Note that the magnitude of the changes is generally small and that changes to DRG weights and wage index values will often offset each other. Nevertheless, it is clear that some groups will be advantaged and others disadvantaged. Generally, large urban hospitals in New England or on the Pacific coast will be benefited most by these changes. Small rural hospitals, especially those in the South, will be disadvantaged most.

The change in blending gives more effect to the Federal national rates and less to hospital-specific rates. Thus, a hospital's payments will be affected by the relation between its Federal national rate and its hospital-specific rate. If the applicable Federal rate is higher, a hospital will benefit; if lower, it will be disadvantaged. Even though the payment rates are maintained at the same level for FY 1986, we expect the average payment per case to increase by about 2 percent, because many FY 1985 discharges occurred during hospitals' cost reporting periods beginning in FY 1984, and thus were paid for using a lower hospital-specific rate.

*K. Conforming and Minor Proposed Regulation Changes*

We are making several other regulation changes that will have relatively minor impacts.

- The revisions to the medical review regulations to conform to the recently published PRO regulations will not have a significant effect on provider revenues.
- The elimination of the prepayment review requirement for all cost outlier payment claims will be administratively simpler for us and for the hospitals, and will give the hospitals quicker payment, but will not affect aggregate revenues significantly.
- The clarification of when hospitals may send denial notices to beneficiaries does not represent a change of policy. It may benefit beneficiaries who might otherwise be sent an inappropriate notice, or hospitals who may not have sent an appropriate notice.

*L. Quality of and Access to Care*

As we have stated on other occasions, the prospective payment system endeavors to change hospital behavior through financial incentives. We are acutely aware of the possibility that for some hospitals, economic incentives might, in some cases, overshadow concerns for the quality of care delivered and access to appropriate services and levels of services.

There are a number of public and private programs involved in evaluating the quality of hospital care. Utilization and Quality Control Peer Review Organizations (PROs) have, under contract with HCFA, responsibility for evaluating whether the quality of services meets professionally recognized standards of health care and may intervene to correct various patient care problems. Sanctions may be applied to hospitals where standards are not met or notices to beneficiaries are improperly utilized. In addition, we survey hospitals for compliance with the health and safety requirements of the conditions of participation for hospitals participating in the Medicare program (42 CFR Part 405 Subpart J). (Hospitals accredited either by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association are deemed to meet these requirements.) Under each of the above programs, we investigate any allegations of poor care. There are additional Federal programs involved in review of specific areas such as radiation safety and infectious diseases. In addition, voluntary second-opinion programs and the efforts of PROs appear to have contributed to a decline in unnecessary surgery.

On the State level, health departments enforce a variety of facility and professional licensure requirements aimed at reducing health care risks and ensuring that only appropriately trained personnel provide services.

Numerous private programs are involved in quality issues. The Joint Commission on Accreditation of Hospitals and the American Osteopathic Association accredit facilities meeting their high standards of care. Almost all of the health professions themselves have and review professional standards of practice. Finally, health care literature suggests that a large number of special research projects are underway, publicly and privately financed, and aimed at measuring various aspects of the quality of hospital care.

The hospital delivery system seems to be adjusting to prospective payment generally as we anticipated, at least as measured by utilization and consumption of resources. We have noted a significant decrease in average length-of-stay and an increase in reported average case mix. To date, there is no systematic evidence linking the behavioral changes that have taken place to any of the potential problems in quality that some expected to result from the changed incentives (for example, shift of acutely ill patients to lower-level providers unable to furnish necessary care, or inappropriate reductions of diagnostic testing or support services). Moderate shifting of patients to less expensive settings has occurred, but the extent of such shifting is not yet known. However, we have seen no data showing an increased number of deaths or complications as a result. Simply stated, a shorter stay in the hospital has not been equated with lower quality care. There may be reason to believe that, in many instances, shorter stays expose patients to fewer risks.

We received a number of comments on the effects of various requirements in this rule on the overall quality of care. These comments generally can be categorized as follows:

- Restraints on payment rates may/will result in a reduction of quality;
- Economic incentives created by prospective payment may/will result in hospital closings or reduction of services provided, thus restricting access;
- Inadequate DRG weighting factors in specific MDCs (for example, in alcohol and drug abuse treatment) may/well result in inadequate treatment; and
- Various technologies (for example, shock wave lithotripsy) may/will be discontinued.

Although none of the comments received on these issues included objective data in support of the assertions, we accept the basic premise that there is an indirect relationship between payment levels and quality of and access to care. We, however, reject the notion that more money equals better care and less money, therefore, must result in poorer care. This argument presented by some commenters ignores the many non-economic variables involved in patient treatment decision-making. We believe that hospital administrators, practicing physicians, and all health care providers are first and foremost guided by the desire to provide the best care possible.

Because payment levels can indirectly affect quality of care, we have been and will continue to be cautious in setting rates and providing for special circumstances. We have evaluated the comments received to date and have made revisions where appropriate. We expect to make many adjustments and policy-revisions in the future, further refining the program as we gain more experience. We encourage those commenters concerned about quality to continue providing us with feedback on the effects of the prospective payment system on patient care.

Ensuring proper access to care is of great concern to us. It is possible that the prospective payment system may in time create incentives for hospitals to establish more outreach programs, expand outpatient services, and form delivery systems to reach populations

that were once ignored. To some extent, this seems to be occurring. The hospital industry's literature encourages hospitals to develop outreach programs and frequently suggests that these will strengthen a hospital's financial picture.

The issues of quality and access are particularly important to certain subgroups of enrollees. Disabled enrollees (especially aged disabled), end-stage renal disease (ESRD) enrollees, and those dually entitled to Medicare and Medicaid coverage ("crossovers") have certain health and socio-economic characteristics that make them particularly vulnerable to changes in health care programs. For example, ESRD enrollees are hospitalized at a rate three times as often as other enrollees. Also, we know that the dually eligible are characterized by higher hospital utilization and costs relative to other aged enrollees. This group represented 2.6 million beneficiaries, or about nine percent of an estimated 28 million aged persons (as of July 1, 1984 according to the U.S. Census Bureau). Thus, a significant portion of the Medicare beneficiary population is particularly sensitive to changes in health care programs and we must ensure that their health care needs are met.

We emphasize our commitment to carefully review the quality of care provided and to investigate any allegations of poor care. We believe that growth in health care expenditures can be restrained without harming patients. In the short-term, we have proper safeguards in place to protect patients. On a long-term basis, there are mechanisms (both public and private) that will enable us to recognize potential problem areas and respond through appropriate changes in policy. The changes contained in this document essentially represent further refinement of the basic prospective payment system. We do not believe any of these changes will create new problems in quality or alter the incentives that might add risks to patient care.

*M. Alternatives Considered*

Throughout the discussions in the preamble and this analysis, we have explained why we are doing one thing rather than another. As noted in section I.B. of the preamble, as part of our analysis we have been considering various approaches to updating DRG weights and wage indexes while trying to minimize fluctuations of payments. Many interrelated decisions are involved in this process, and the number of possible combinations of different wage indexes, different DRG weights, and different update factors is large. Further, there are additional alternatives that had to be considered within each of the key technical methodologies for deriving the proposed wage index, DRG weights, and Federal rates. Altogether, there is a potentially enormous number of permutations.

Nonetheless, we have been particularly concerned with the impact of certain main options, and we have reviewed them in the light of how they would interact with each other. These include, for example, using unstandardized DRG weights, rather than weights standardized for geographic wage differences and indirect medical education. This would have had the effect of "decompressing" average case mix relative to standardized weights and would have disadvantaged rural hospitals. We also considered all the ProPAC recommendations. Each of the factors taken into consideration in the development of the FY 1986 standardized amounts was challenged and debated both individually and in combination with other factors.

*N. Summary and Conclusions*

E.O. 12291 requires us to assess the benefits, costs, and net benefits of all rules, major or otherwise. For major rules, we must discuss those costs and benefits in impact analyses, and show that the potential benefits outweigh the potential cost to society. In addition, we must discuss alternative methods of achieving the objectives we propose in our regulations. Throughout the preamble, addendum, and other sections of this impact analysis, such alternatives are discussed. In this summary, we assess the overall costs of the changes we are making, the overall benefits, and the resulting net benefits.

For the most part, the costs and disadvantages that may result from these changes will take the form of reductions in anticipated revenue to affected hospitals. Most of the changes will have their major effect through their influence on the level of FY 1986 prospective payments. The only significant exception will be the retroactive application of the revised wage index.

As we have said before, the primary benefit expected to result from this rule is the maintenance and effective management of the prospective payment system itself. The incentives of this system are expected to produce substantial benefits in the form of economical and efficient operation of participating hospitals, and as improvements in trends of the health care marketplace as a whole. As noted earlier, the objective of these changes is to refine the prospective payment system. Whereas the system as a whole has had a large and dramatic impact, the refinements are of a marginal nature, rather than large-scale adjustments.

We believe that, from this perspective, the overall benefits to society more than offset any resulting liabilities. For the above reasons, we believe that this analysis meets the objectives of E.O. 12291 and the RFA as noted in the Introduction to the Regulatory Impact Analysis.

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September 3, 1985

Part IV

# Department of the Interior

Fish and Wildlife Service

50 CFR Part 20

Final Migratory Bird Hunting Regulations on Certain Federal Indian Reservations, Indian Territory, and Ceded Lands; Final Rule

DEPARTMENT OF THE INTERIOR

50 CFR Part 20

## Final Migratory Bird Hunting Regulations on Certain Federal Indian Reservations, Indian Territory, and Ceded Lands

**AGENCY:** Fish and Wildlife Service, Interior.

**ACTION:** Final rule.

**SUMMARY:** This rule prescribes final hunting regulations to be established for certain tribes on Federal Indian reservations, Indian Territory, and ceded lands in the 1985–86 hunting season. The rule also implements revised guidelines for establishing migratory bird hunting regulations on Federal Indian reservations, Indian Territory, and ceded lands. However, because of the complex nature of the subject, and the need for ample time for comment, the comment period on the guidelines will remain open indefinitely. These final regulations contain no information collections subject to Office of Management and Budget review under the Paperwork Reduction Act of 1980.

**EFFECTIVE DATE:** This rule takes effect on September 1, 1985.

**ADDRESSES:** Comments received on the proposed regulations for certain tribes, the proposed guidelines for establishing regulations, and the environmental assessment are available for public inspection during normal business hours in room 536, Matomic Building, 1717 H Street, NW., Washington, D.C. Communications regarding the documents should be directed to Director (FWS/MBMO), Room 536, Matomic Building, U.S. Fish and Wildlife Service, Washington, D.C. 20240.

**FOR FURTHER INFORMATION CONTACT:** Rollin D. Sparrowe, U.S. Fish and Wildlife Service, Department of Interior, Washington, D.C. 20240 (202) 254–3207.

**SUPPLEMENTARY INFORMATION:** The Migratory Bird Treaty Act of July 3, 1918 (40 Stat. 755; 16 U.S.C. 703 et seq.), authorizes and directs the Secretary of the Interior, having due regard for the zones of temperature and for the distribution, abundance, economic value, breeding habits, and times and lines of flight of migratory game birds, to determine when, to what extent, and by what means such birds or any part, nest or egg thereof may be taken, hunted, captured, killed, possessed, sold, purchased, shipped, carried, exported or transported.

In the June 4, 1985, **Federal Register** (50 FR 23459–23470 and particularly 23467–23468), the U.S. Fish and Wildlife Service (hereinafter the Service) proposed revised guidelines for migratory bird hunting regulations on Federal Indian reservations, Indian Terrority, and ceded lands. The guidelines would replace proposed criteria published in the March 23, 1984, **Federal Register** (49 FR 11125–11126). The revised guidelines were prepared in response to tribal assertion of reserved hunting rights, and tribal interest in exercising these rights. The guidelines include possibilities for: (1) On-reservation hunting (including Indian Terrority), by both tribal and non-tribal members, with hunting by non-tribal members on some reservations to take place within Federal frameworks but on dates different from those selected by surrounding State(s); (2) on-reservation hunting (including Indian Territory) by tribal members only, outside of usual Federal frameworks; and (3) off-reservation hunting by tribal members on ceded lands, outside of usual framework dates and season length, with some added flexibility in daily bag and possession limits. In all cases, the regulations established under the proposed guidelines would have to be consistent with the closed season requirement mandated by the 1916 Migratory Bird Treaty with Canada.

The Service requested comments on the proposed guidelines and on a draft environmental assessment that evaluates their likely impacts. The Service also indicated the intention to establish special regulations for some tribes in the 1985–86 hunting season. Tribes that desired special seasons were asked to submit a proposal that included details on anticipated harvest, methods that would be used to monitor harvest, steps that would be taken to limit harvest where it could be shown that failure to do so would impact seriously on the resource, and tribal capabilities to establish and enforce migratory bird hunting regulations.

Four State conservation agencies wrote the Service in regard to the proposed guidelines, and their comments are discussed in the August 6, 1985, **Federal Register** (50 FR 31828). The States generally recognize the special status of reserved hunting rights of Indian tribes and the need to provide flexibility in this area. However, the comments reflected concern regarding the potential adverse effects that the ad hoc exercise of these hunting rights and management authority could have on the waterfowl resource and on State waterfowl management programs. In a July 30, 1985, letter that was received too late for inclusion in the August 6, 1985, **Federal Register**, Mr. James H. Glass, President, The Wildlife Legislative Fund of America, stated his concern that the guidelines offer the possibility for longer hunting seasons and higher bag limits for Indians than non-Indians, even in cases where both will be hunting on the same public lands. In his letter, Mr. Glass recognized that the treaty hunting rights of Indians cannot be ignored. However, he urged the Service to stand for regulations that are designed to protect and improve the resource for all people, whether Indian or non-Indian.

The Service recognizes that the guidelines may provide greater hunting opportunities in some instances for Indians than for non-Indians, and that this will be viewed as discriminatory by some non-Indians. Nevertheless, the Service believes that it is appropriate to recognize the unique nature of the reserved hunting rights of Indian tribes and, to the extent possible and commensurate with the conservation of the resource, to provide them reasonable flexibility in hunting regulations. As discussed in the June 4, 1985, **Federal Register**, the Service believes that hunting by tribal members is unlikely to cause a substantial increase in migratory bird harvest. However, hunting seasons on ceded lands and hunting seasons for non-tribal members on Federal Indian reservations where tribes have full wildlife management authority could result in increased harvest. The Service will scrutinize proposals for such seasons carefully to ensure that they do not have serious impacts on the migratory bird resource, and most seasons will be experimental.

Five Indian tribes, bands, and Indian organizations also commented on the June 7, 1985, proposed guidelines. Their comments and the Service responses are summarized in the August 6, 1985, **Federal Register** (50 FR 31829–31833), in which the Service announced proposed regulations in the 1985–86 hunting season for certain Indian tribes.

On August 14, 1985, Mr. Allen R. McKay, Director of the Game and Fish Division, Three Affiliated Tribes, Fort Berthold Reservation, New Town, North Dakota, commented on the proposed guidelines and the draft environmental assessment. Mr. McKay stressed that the Three Affiliated Tribes (Mandan, Hidatsa, and Arikara) assert jurisdiction over hunting by tribal and non-tribal members on the reservation. He stated that the tribes support the guildeline that would permit establishment of seasons for non-tribal members that might differ from the State regulations, but the tribes do not request action at this time. Mr. McKay indicated that the tribes have the capability to establish and enforce

migratory bird hunting regulations, and that they would like to be included in meetings or correspondence regarding establishment of waterfowl hunting regulations that affect the Three Affiliated Tribes.

In earlier **Federal Registers** the Service has stated that Indian tribes that wish to do so should have the opportunity to participate in technical meetings on migratory bird matters. The Service intends to investigate ways in which this can be accomplished.

While there were some questions and concerns raised by Indian tribes and organizations, their comments generally were supportive of the revised guidelines and of the Service's attempts to develop reasonably uniform standards dealing with reserved hunting rights of Indian tribes. The Shoshone-Bannock Tribes on the Fort Hall Reservaton in Idaho are an exception. In letters dated June 27, 1985, and August 16, 1985, the tribes raised a number of objections to the guidelines. Among other things, Mr. John D. Ross III, Tribal Attorney, pointed out that a number of tribes were not aware of the proposed guidelines published in the June 4, 1985, **Federal Register** and thus did not have an opportunity to comment on them. The Service believes that tribes on all Federal Indian reservations should have this opportunity and, therefore, the Service intends to keep the comment period on the guidelines open indefinitely, and to ensure that all tribes receive them for review. The Service has acknowledged that the revised guidelines might not cover all situations. For this reason, some changes may be required, and they should not be viewed as inflexible. However, the Service believes they are reasonable and necessary interim standards to employ in establishing migratory bird hunting regulations for Indian tribes, and they will be used for his purpose for the affected tribes in the 1985–86 hunting season.

### Nontoxic Shot Regulations

In the February 12, 1985, **Federal Register** (50 FR 5759–5764) and more recently in the May 7, 1985, **Federal Register** (50 FR 19178–19182), the Service published a list of zones and areas where nontoxic shot will be required for waterfowl hunting in the 1985–86 hunting season.

More recently, on June 14, 1985, the National Wildlife Federation sued the Department of the Interior to block use of lead shotgun ammunition for waterfowl hunting in parts of 22 counties in California, Illinois, Missouri, Oklahoma, and Oregon. The issues in the case involve the protection of the endangered bald eagle from lead poisoning. The outcome of this lawsuit could have a bearing on future nontoxic shot regulations on Federal Indian reservations and ceded lands where waterfowl are hunted by tribal and non-tribal members.

### NEPA Consideration

The "Final Environmental Statement for the Issuance of Annual Regulations Permitting the Sport Hunting of Migratory Birds (FES 75–54)" was filed with the Council of Environmental Quality on June 6, 1975, and notice of availability was published in the **Federal Register** on June 13, 1975 (40 FR 25242). In addition, several environmental assessments have been prepared on specific matters that serve to supplement the material in the Final Environmental Statement. Of particular importance is the environmental assessment, "Guidelines for Migratory Bird Hunting Regulations on Federal Indian Reservations and Ceded Lands" that was distributed for review and public comment on June 4, 1985. The Service has concluded that the action proposed in the assessment is not a major Federal Action that would significantly affect the quality of the human environment within the meaning of Section 102(2)(c) of the National Environmental Policy Act of 1969. Accordingly, the preparation of an environmental impact statement on the proposed action is not required. Copies of the assessment are available from the Office of Migratory Bird Management, U.S. Fish and Wildlife Service, Room 536, Matomic Building, Washington, D.C. 20240.

### Endangered Species Act Consideration

Section 7 of the Endangered Species Act provides that, "The Secretary shall review other programs administered by him and utilize such programs in furtherance of the purposes of this Act" [and] "by taking such action necessary to insure that any action authorized, funded or carried out . . . is not likely to jeopardize the continued existence of such endangered or threatened species or result in the destruction or modification of habitat of such species . . . which is determined to be critical." Consequently, the Service initiated Section 7 consultation under the Endangered Species Act for the proposed hunting seasons on Federal Indian Reservations, Indian Territory, and ceded lands. On June 18, 1985, the Acting Chief, Office of Endangered Species, gave a biological opinion that the proposed action is not likely to jeopardize the continued existence of listed species or result in the destruction of adverse modification of their critical habitats.

### Regulations Promulgation

The rulemaking process for migratory bird hunting must, by its nature, operate under severe time constraints. However, the Service is of the view that every attempt should be made to give the public the greatest possible opportunity to comment on the regulations. Thus, when the proposed guidelines were published on June 4, 1985, and when the proposed hunting regulations for certain tribes were published on August 6, 1985, the Service established the longest period possible for public comment. In doing this the Service recognized that time would be of the essence. The comment periods provided the maximum amount of time possible while ensuring that a final rule was published before the beginning of the hunting season on September 1, 1985. The Navajo Nation's regulatory proposal has been adopted in this final rule, even though it was not described in the proposed rule of August 6, 1985. The Service finds that, because its guidelines on Native American hunting on Indian reservations have been the subject of repeated public comment and review, and because the Navajo's proposal falls within prescribed Federal frameworks, good cause exists for adopting the Navajo regulations in this final rule. To require a new public comment period at this stage of the rulemaking process for migratory game hunting would be impracticable, unnecessary, and contrary to the public interest.

Therefore, under authority of the Migratory Bird Treaty Act of July 3, 1918, as amended (40 Stat. 755; 16 U.S.C. 703 et seq.), the Service prescribes the final hunting regulations for certain tribes on Federal Indian reservations, Indian Territory, and ceded lands. The regulations specify the species to be hunted and establish season dates, bag and possession limits, season length, and shooting hours for migratory game birds other than waterfowl. However, final Federal frameworks for waterfowl hunting seasons (opening and closing framework dates, daily bag and possession limits, etc.) are planned for publication on September 2, 1985. Because it was necessary to publishing this document by September 1, 1985, most waterfowl regulations for the tribes listed here are shown as within final frameworks to be established.

The Service finds that "good cause" exists, within the terms of 5 U.S.C. 553(d)(3) of the Administrative Procedure Act, and this final rule will,

therefore, take effect on September 1, 1985.

**Regulatory Flexibility Act and Executive Order 12291**

In the **Federal Register** dated March 14, 1985 (at 50 FR 10282), the Service reported measures it had undertaken to comply with requirements of the Regulatory Flexibility Act and the Executive Order. These included preparing a Determination of Effects and an updated Final Regulatory Impact Analysis, and publication of a summary of the latter. These regulations have been determined to be major under Executive Order 12291 and they have a significant economic impact on substantial numbers of small entities under the Regulatory Flexibility Act. This determination is detailed in the aforementioned documents which are available upon request from the Office of Migratory Bird Management, U.S. Fish and Wildlife Service, Department of the Interior, Washington, D.C. 20240.

**Memorandum of Law**

The Service published its Memorandum of Law, required by Section 4 of Executive Order 12291, in the **Federal Register** dated July 26, 1985 (at 50 FR 30424).

**Authorship**

The primary author of this proposed rulemaking is Fant W. Martin, Office of Migratory Bird Management, working under the direction of Rollin D. Sparrowe, Chief.

**List of Subjects in 50 CFR Part 20**

Hunting, Wildlife, Exports, Imports, Transportation.

Accordingly, 50 CFR Part 20 is amended as follows:

## PART 20—[AMENDED]

1. The authority citation for Part 20 continues to read as follows:

Authority: Migratory Bird Treaty Act, sec. 3, Pub. L. 65–186, 40 Stat. 755 (16 U.S.C. 704); sec 3(h), Pub. L. 95–616, 92 Stat. 3112 (16 U.S.C. 712), unless otherwise noted.

2. Section 20.110 is added to read as follows:

**§ 20.110 Seasons, limits, and other regulations for certain Federal Indian reservations, Indian Territory, and ceded lands.**

This section provides for establishing annual migratory bird hunting regulations for certain tribes on Federal Indian reservations, Indian Territory, and ceded lands.

(Editorial Note.—The following annual hunting regulations will not appear in the Code of Federal Regulations because of their seasonal nature)

**§ 20.110 Seasons, limits, and other regulations for certain Federal Indian reservations, Indian Territory, and ceded lands.**

(a) *Great Lakes Indian Fish and Wildlife Commission.* In letters dated August 15, 1985, and August 19, 1985, the Commission and the Wisconsin Department of Natural Resources, respectively, accepted the following experimental hunting regulations proposed by the Service for Chippewa tribal members hunting on ceded lands in public ownership in Wisconsin, which are hereby adopted in this final rule for the 1985–86 season:

(1) *Ducks*[1]

*Season Dates:* Begin 15 days prior to opening of regular Wisconsin duck season. End with closure of State hunting season.

*Daily Bag and Possession Limits:* Same as permitted under Federal frameworks.

*Special Scaup-only Season:* Same dates, season length, and daily bag and possession limits permitted Wisconsin under Federal frameworks.

*Rest Period:* A 5-day non-hunting period beginning 5 days before the regular State duck hunting season.

(2) *Geese*[1]

(i) *Canada Geese*

*Season Dates:* Same as permitted under Federal frameworks.

*Bag and Possession Limits:* Daily bag limit 3. Possession limit.

6. No season limit.

(ii) *Other Geese* (Snow Geese, Blue Geese, White-fronted Geese): Same dates, season length, and daily bag and possession limits permitted Wisconsin under Federal frameworks.

(3) *Other migratory birds.*

(i) *Coots, Common Moorhens, and Purple Gallinules (Gallinules)*

*Season Dates:* Same as for ducks.

*Bag limit:* 15 daily, singly or in aggregate. Possession limit 30.

(ii) *Sora and Virginia Rails*

*Season Dates:* September 15 through November 19.

*Bag Limit:* 25 daily, singly or in aggregate. Possession limit 30.

(iii) *Common Snipe*

*Season Dates:* September 15 through November 19.

*Bag Limit:* 8 daily. Possession limit 16.

(iiii) *Woodcock*

*Season Dates:* September 15 through November 18.

*Bag Limit:* 5 daily. Possession limit 10.

[1] Final frameworks for waterfowl to be established.

(4) *General conditions.* Tribal members will comply with all basic Federal migratory bird hunting regulations, 50 CFR Part 20, shooting hour regulations, 50 CFR Part 20, Subpart K, and nontoxic shot zone regulations, 50 CFR 20.108. For purposes of enforcing bag and possession limits, all waterfowl or other migratory birds in the possession or custody of tribal hunters on ceded lands will be considered to have been taken on these lands.

(b) *Colorado River Indian Reservation.* The following regulations will apply to both tribal and non-tribal members while hunting on the reservation during in 1985–86 hunting season:

(1) *Ducks*[1]

*Season Dates:* Same as Arizona and Colorado River Zone in California.

*Daily Bag and Possession Limits:* Same as permitted under Federal frameworks for Arizona and Colorado River Zone in California.

(2) *Geese*[1]

*Season Dates:* Same as Arizona and Colorado River Zone in California.

*Daily Bag and Possession Limits:* Same as permitted under Federal frameworks for Arizona and Colorado River Zone in California.

(3) *Other migratory birds*

(i) *Coots and Common Moorhens (Gallinule)*

*Season Dates:* Same as for ducks in Arizona and Colorado River Zone in California.

*Daily Bag and Possession Limits:* 25 singly or in aggregate.

(ii) *Common Snipe*

*Season Dates:* Same as for ducks in Arizona and Colorado River Zone in California.

*Daily Bag and Possession Limits:* 8 daily. Possession limit 16.

(iii) *Mourning Doves and White-winged Doves*

*Season Dates:* September 1–October 15; November 16–November 30.

*Daily Bag and Possession Limits:* Daily bag limit is 15 and possession limit is 30 mourning and white-winged doves, singly or in the aggregate of these species; however, the bag and possession limits of white-winged doves may not exceed 10 and 20, respectively.

(4) *General conditions.* Tribal and non-tribal hunters will comply with all basic Federal migratory bird hunting regulations in 50 CFR Part 20 regarding shooting hours and manner of taking. In addition, each waterfowl hunter 16 years of age or over must carry on his person a valid Migratory Bird Hunting and Conservation Stamp, or duck stamp, signed in ink across the face. Hunters

under 16 may voluntarily purchase a duck stamp and help preserve wetlands for waterfowl. Special regulations established by the Colorado River Indian Tribes also may apply on the reservation.

(c) *Penobscot Indian Nation.* (1) In a June 25, 1985, letter, the tribe proposed to adopt 2 separate migratory bird seasons: a general season for both tribal and non-tribal members, and a sustenance season for tribal members only. The general season would be the same as selected by the State of Maine, as has been the case in the past. The proposed sustenance season would include only ducks and would begin on September 21 and end on November 30, and it would permit Sunday hunting (not permitted under State regulations). The daily bag limit under sustenance hunting regulations would be 4 ducks, with no more than 2 wood ducks or 2 black ducks. Where sustenance and general seasons coincide, the daily bag limit for any species or in total would be the greater of the 2 possible limits. All usual Federal basic regulations would apply.

(2) In a letter to the Service dated July 19, 1985, Mr. Norman Trask, Maine Department of Inland Fish and Wildlife, expressed concern regarding the proposed black duck regulations. Mr. Trask pointed out that the more liberal tribal regulations might erode continued support by non-Indians for the restrictive regulations that have been set in the State during the past 3 years to reduce black duck harvest.

(3) The Service did not object to the tribe adopting different hunting regulations for tribal and non-tribal members. The guidelines provide for this possibility. However, in the August 6, 1985, **Federal Register**, the Service proposed that the tribe limit subsistence harvest to species that are more abundant than the black duck. In an August 15, 1985, response, Mr. Tim Lukas, Wildlife Biologist for the tribe indicated that the Service proposal was not feasible for several reasons and asked that the Service approve the tribal proposal. Mr. Lukas requested consultation with the Service and State if there were continuing concerns regarding the tribal proposal. The Service met with tribal and State officials on August 21, 1985. At the meeting, tribal officials assured the Service that the subsistence harvest would be too small to impact adversely on local populations and that the tribe would carefully monitor the harvest to ensure that this is the case. The Service has approved the 1985 sustenance hunting regulations on an experimental basis, pending an evaluation.

(d) *White Earth and Other Minnesota Chippewa Indians.* In a June 27, 1985, letter, Mr. Dwight Wilcox, White Earth Reservation Biologist, submitted proposed 1985 migratory bird hunting regulations for on-reservation hunting by tribal members. Mr. Wilcox suggested that a memorandum of agreement between the White Earth Tribal Council and the Service may be appropriate. The Service concurred with this suggestion in the August 6, 1985, **Federal Register** and has subsequently arranged a meeting for this purpose with Tribal Council officials. The Service also intends to consult with officials of other Chippewa Indian reservations in Minnesota, with the aim of reaching agreement on 1985 hunting regulations.

(e) *The Navajo Nation.* (1) In a June 29, 1984, letter, Mr. John E. Antonio, Director, Navajo Game and Fish Program, stated that the Navajo Nation has full wildlife management authority, and he submitted a proposal for uniform migratory bird hunting regulations throughout the reservation (in parts of Arizona, New Mexico, and Utah). The proposed regulations would apply to both tribal and non-tribal hunters. The Service had not developed the revised guidelines at that time and the proposal could not be approved. However, in the June 4, 1985, **Federal Register**, the Service announced the intention to establish uniform regulations on the reservation in the 1985–86 hunting season.

(2) In an August 20, 1985, telephone conversation, Mr. Antonio requested that the Service approve regulations for the 1985–86 hunting season. Mr. Antonio indicated that it had not been possible to make a request earlier, and that the tribe would meet all law enforcement and other criteria for special seasons that were described in the June 4, 1985, **Federal Register**. The 1985–86 hunting regulations proposed by the tribe are more restrictive than Federal frameworks permit, and the Service approves the following regulations for both tribal and non-tribal members in the 1985–86 hunting season, on an experimental basis, pending an evaluation of hunting activity and harvest:

(i) *Ducks* [1]

*Season Dates:* October 12, 1985–December 1, 1985.

*Daily Bag and Possession Limits:* Same as permitted Pacific Flyway States under Federal frameworks.

(ii) *Geese*

*Canada Geese* (season closed on other geese):

*Season Dates:* December 28, 1985–January 5, 1986.

*Daily Bag and Possession Limits:* 2 per season.

(iii) *Other migratory birds*

(A) *Coots and Common Moorhens (Gallinule)*

*Season Dates:* October 12, 1985–December 1, 1985.

*Daily Bag and Possession Limits:* 25 singly or in aggregate.

(B) *Mourning Doves*

*Season Dates:* September 7, 1985–September 29, 1985.

*Daily Bag and Possession Limits:* 12 daily. Possession limit 24.

(C) *Band-tailed Pigeons*

*Season Dates:* September 7, 1985–September 29, 1985.

*Daily Bag and Possession Limits:* 5 daily. Possession limit 10.

(iv) *General conditions.* Tribal and non-tribal hunters will comply with all basic Federal migratory bird hunting regulations in 50 CFR Part 20 regarding shooting hours and manner of taking. In addition, each waterfowl hunter 16 years of age or over must carry on his person a valid Migratory Bird Hunting and Conservation Stamp, or duck stamp, signed in ink across the face. Hunters under 16 may voluntarily purchase a duck stamp and help preserve wetlands for waterfowl. Special regulations established by the Navajo Nation also may apply on the reservation.

The final rule promulgated here that implements interim guidelines for migratory bird hunting regulations on Federal Indian reservations, Indian Territory, and ceded lands, and that also establishes final hunting regulations for certain tribes for the 1985–86 hunting season is authorized under the Migratory Bird Treaty Act of July 3, 1918 (40 Stat. 755; 16 U.S.C. 703 et seq.), as amended.

Dated: August 23, 1985.

**P. Daniel Smith,**

*Acting Deputy Assistant Secretary for Fish and Wildlife and Parks.*

[FR Doc. 85-20726 Filed 8-29-85; 4:12 pm]

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## TABLE OF EFFECTIVE DATES AND TIME PERIODS—SEPTEMBER 1985

This table is for determining dates in documents which give advance notice of compliance, impose time limits on public response, or announce meetings.

Agencies using this table in planning publication of their documents must allow sufficient time for printing production.

In computing these dates, the day after publication is counted as the first day.

When a date falls on a weekend or a holiday, the next Federal business day is used. (See 1 CFR 18.17)

A new table will be published in the first issue of each month.

| Dates of FR publication | 15 days after publication | 30 days after publication | 45 days after publication | 60 days after publication | 90 days after publication |
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## CFR CHECKLIST

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An asterisk (*) precedes each entry that has been issued since last week and which is now available for sale at the Government Printing Office.

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[1] No amendments to this volume were promulgated during the period Apr. 1, 1980 to March 31, 1985. The CFR volume issued as of Apr. 1, 1980, should be retained.

[2] No amendments to this volume were promulgated during the period Apr. 1, 1984 to March 31, 1985. The CFR volume issued as of Apr. 1, 1984, should be retained.

[3] No amendments to this volume were promulgated during the period July 1, 1984 to June 30, 1985. The CFR volume issued as of July 1, 1984, should be retained.

[4] The July 1, 1985 edition of 41 CFR Chapters 1–100 contains a note only for Chapters 1 to 49 inclusive. For the full text of procurement regulations in Chapters 1 to 49, consult the eleven CFR volumes issued as of July 1, 1984 containing those chapters.